		•	For State Registrar	State of Marylan	d / Depa	artmei <i>rtifica</i>	nt of H	ealth and I Death	Mental Hyg	giene Reg. No.	2004	34001
	Physici		Decedent's Name (First, Middle, Last) CHADWICK LOWEL	L TRENT,	SR.				2. Date of Dea Month OCT • 7	Day	Year	3. Time of Death 3:11 P M
	/Medic Examin		4a. Facility Name (If not institution, give st					Location of Death		4c.	County of Death	
	Funeral Director		ANNE ARUNDEL MEDIC. 5. Social Security Number 6. Sex 132-52-3090	7. Age (In yrs.	last birthday) Yrs.		APOL.	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Dat AUG. 20	h V Year)	ANNE AR 9. Birth Coo	place (State or Foreign intry) TVIRGINIA
	D D		Usual Residence of Decedent 10a, State 10b, County	10c. Cit	y, Town or L	ocation						10d. Inside City Limits
	death with the Maryland ims 23a or 28a-f show if nast be notified at	lor	MARYLAND PRINCE G		OLLEGE							1 Yes 2 □ No
	or 28a	Director	10e. Street and Number			10f. Z	p Code			10g. Citi:	zen of What Co	untry?
	ath wi		5117 KENESAW STREE	T 2. Was Decedent Ever in U.	C 12		20740	anania Origina (S		U.S.	A. 14. Race - Amer	ican Indian
	72 hours after death with the Marylan "neturet", or items 23a or 28a-1 show clical Expression countries at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 MYes 2 □ No If Yes, Give 1953- Year or Dates:	-55 Is.	If Yes, sp		spanic Origin? (S n, Mexican, Puerl Specify:	o Rican, etc.)		Black, White	, etc.
2-0036	72 hou		15. Decedent's Education (Specify only highest grade	ation completed)	(Give	kind of w	ual Occupa	luring most of wor	rking		nd of Business/I	•
Z	within then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	1		CAL I) ENGINEER				CONTROLLING
12.01	Hygin	Be Co	17. Father's Name (First, Middle, Last)						ne (First, Middle,	Maiden	Sumame)	
Maryland	should be and Mental smarked c umatic eve	ToE	WILLIAM SHERMAN TR				10.00		DELUNG	0.4	- T C4-4- 7	To Code
Za	d2sh thand t7 is m traum		19a. Informant's Name/Relationship (Type SHIRLEY W. TRENT/W					STREET.				LAND 20740
re,	iges 1 and 2 should k it of Health and Ment it item 27 is marked or other traumatic		20a. Method of Disposition	20b. F	Place of Disponentery, cre				Date		ocation - City or	
E	Pages ment of ant: If its ury or o		1 ☐ Burial 2 【ACremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	HUI	NTT CR	EMAT()RY	10/	11/2004		DORF, M	
Baltimore,	permit. Page Department of Important: If eny injury or ance.		21. Signature of Funeral Service License	-{	1	6000	ANNA	POLIS RO	AD, BOWI	E, M		
	Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)		Svain			g, such as cardia	or respiratory ai	rest,		Approximate Interval Between Onset and Death
t	Examiner		Conventially list conditions	200 10 101 20 2 0011000	201100 017.							
	sit ad	lner	Sequentially list conditions, if any, labourg or insured late cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):									
60,	icate be executed physician and s the burial-transit											
68760,		d								Ì	1,	
D. Box	ath cer ttendir or use	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of pregni 1 Live birth 2 Feta 4 Pregnant at time of c 9 Unknown	if death 3	□Ectopic □ Other (pregnancy specify)				23d. Date of deli Month	very Day Year
P.0	res that the de signed by the a l be detached f		Part II. Dther significant conditions con-	ributing to death but not res	sulting in the	underlying	cause give	en in Part I.	23e. Did t	obacco u	use contribute to	the cause of death?
rds	w requires been sign should be	ed by							1 🗆 '	Yes 2	MNo 3□Pr	obably 4 \(\sum \text{Unknown}\)
Records,	The law re cate has bee page 2 sho	Completed					-,		24a. Was autop perfo 1 Tes	osy irmed?	prior to death?	topsy findings available completion of cause of 2 \(\sum \) No
/ita	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	ospital:			Oth	ar	ath (Check only o			
of	Physic r this c ral dire	To	1 ☐ Yes 2 🕅 No	28a. Date of Injury (Month, Day Year)	28b. Time		28c. Injun	4 Nursing i	dome 5 Resi	-		cify)
on	ath. r: After e funer	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	М		k? Yes 2 □No				
Division of Vital	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director After this certifical completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci		treet, facto	ory, office		28f. Location (. City or To	Street an wn, State	nd Number or Ru e)	iral Route Number,
	To the Hospital within 24 hours a To the Funeral completely filled	Medical		ician: To the best of my knower: On the basis of examination and manner stated.						date and	d place, and due	to the cause(s)
):	To th within To th comp	M	29b. Signature and title of our man	Bech, MD		2	9c. Licens	46052		29d. Dat	te signed (Monti	h, Day, Year)
			30. Name and address of person who co Single of Bull (1) 31. Date filed (Month, Day, Year)	mpleted cause of death (Ite)	m 23a) (Type	Panh	NAY	annap	dos, ru			
	St Regist	ate	31. Date filed (Month, Day, Year)	32. egistrar's Sign	ature	had	,					

		For Stete Registrar	- (Fina Adiddle)		arylar		artment of F			Reg. No.	004	34002
Physiciar /Medica	1	Madeleir	ne Eliz	abeth Ute	endal	nl	4h City Town	r Location of Death	Month 10	10 Day	Year 04 ounty of Death	3. Time of Death 1:15 A M
Examine Funeral		8209 Hea	atherwic	. Sex 7. Ag		last birthday	Brandy	wine If Under 24 Hrs.	8. Date of Bir	PR 8. Date of Birth		Dolace (State or Foreign
Director		129-14-	Decedent	1□ M 2🔀 F	31	Yrs.	Months Days	Hours Min.	(Month, Da	23	New	York
Ba-f show	Director	MD	PR Geo	Co		ity, Town or L andywij	ne				10d. Inside City 1 🗀 Yes 🦸	
in 1 Period 2		8209 Heat			10f. Zip Code 20613 It Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe			10g. Citizen of What Co USA acify Yes or No- 14. Race - Ame				
	by Funeral	11. Marital Status 1 ☐ Never Marri 3 🏋 Widowed	ied 2 Married 4 Divorced	Armed Forces?	,	7.3.	If Yes, specify Cuba 1 ☐ Yes 2X No	Specify:	Rican, etc.)	S	, etc.	
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ental Hygie ked other ic event,	10 Be Co	17. Father's Name		2 yrs enkins		Clerical/Administrative 18. Mother's Name (# Mary Loui			e (First, Middle,			
alth and M 27 Is mar er treumat	-	19a. Informant's Na Myra Rigo					ing Address (Street Heatherw	and Number or Rur	al Route Numbe	er, City or T	own, State, Zi	,
nent of He ent: If item ury or oth				☐Removal from State	_	cemetery, cre	osition (Name of omatory or other place nather Natl Cer	ce)	Date 0/18/04		tion - City or T York Ci	
Departi Import any inj once.		21. Signature of Fu	ineral Service Lid	//			2. Name and Addre	Bel	l Funer			
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te has been signed by the attending physbage 2 should be detached for use as the	Physician/medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □								230	d. Date of deliv Month	rery Day Year
en signed b	2	Part ii. Other significant conditions contributing to death out not resulting in the dilderlying cause given in Part i.								~	the cause of death?	
cate has be	Completed								24a. Was autop perfo 1 \(\text{Yes}	an 2 sy rmed 22No	death?	opsy findings available ompletion of cause of 2 No
this cer al direct	Certification: 10 be	25. Was case referred to medical examiner? 1										
24 hours a e Funerel I letely filled i	ledical Ce	29a. Certifier (Check only one)	Certifying 2 Medical Ex	Physician: To the best raminer: On the basis of and manner st	it examin:	owledge, dea ation and/or in	th occurred at the tin	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and pla	ed manner as s ace, and due t	stated. o the cause(s)
withir To th comp	Me	29b. Signature and	title of confiler				29c. Licens	e number 9431			igned (Month,	
-(8)		30. Name and a	M. Ry	no completed cause of c	leath (Ite	LIVI	Print)	12 4 10	3 77-	WAR	11404	Undroxy
State Registra		OCT	4		ur a digit	he	R.					

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 200 l 34003 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician OCTOBER 11, LESLIE C. VENABLE, SR. 2004 5:00A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** VA MARYLAND HEALTH CARE SYSTEM PERRY POINT CECIL 8. Date of Birth (Month, Day, Feb 27, 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 9. Birthplace (State or Foreign **Funeral** North Carolina 238-20-2401 79 Director 1925 Usual Residence of Decedent the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Directo Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 101 Spesutia Road 21001 USA Funerai death 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 1942–45 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or item any njury or other traumatic event, the Marital Experiment once. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: Black Completed by 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Security Guard US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John H. Venable 2 Arah Willis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Venable / wife 101 Spesutia Road, Aberdeen, MD 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State Berkley Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 10/16/04 Darlington, MD 22. Name and Address of Facility
Lisa Scott Funeral Home, P.A.
552 Lewis Street, Havre de Grace, MD 21078 21. Signature of Funeral Service Licensee Disawat 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MYOCARDIAL INFARCTION UNKNOWN /Medical Due to (or as a consequence of): **Examiner** HYPERTENSION UNIVERSITY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) nding physiclan and use as the burial-translt resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown baen signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ALZHEIMER'S DISEASE Completed 1 Yes 2 No 3 Probably 4 Nunknown ALCOHOL RELATED DEMENTIA 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed?

To the Hospital or Attanding Physician: The law requires that the death certificate be exacuted Box 68760. o. ۵ Division of Vital Records, certificete funeral After death. Director:

Baltimore, Maryland 21215-0036

PHYSICIAN:

within 24 hours a

Be

Certification; To

Medicai

29a. Certifier

(Check only one)

29b. Signature and title of certifier

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death

5 Pending investigation 1 X Natural 2 Accident 3 Suicide 6 Could not be

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

1 ☐ Inpatient 2 ☐ ER/Outpatient

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

28a. Date of Injury (Month, Day Year)

29c. License numbe D24648

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

26. Place of Death (Check only one)

OCTOBER 11, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MARYLAND SHER A. HASHMI, M.D.,

3□ DOA

State Registrar

31. Date filed (Month, Day, Year) OCT 1 2 2004



			1 - State of Maryland / I	Department of F Certificate of	lealth and M <i>Death</i>	lental Hygid	200	34004
			Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	3. Time of Death
	Physicia /Medic		John McClain Veatch, Sr.			October		
7	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, o	r Location of Death		4c. County of	
			5546 Woodridge Dr.	Waldors			Char	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bi	Yrs. Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,)		Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent			July 22,	,1927	Washington, DC
	yland		10a. State 10b. County 10c. City, Tow	vn or Location				10d. Inside City Limits
	Mar-1 st	to	Maryland Charles Wa	ldorf				1 ☐ Yes 2♣ No
	or 28	Director	10e. Street and Number	10f. Zip Code		100	g. Citizen of W	hat Country?
	23a		5546 Woodridge Dr.	206	01		USA	A
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event. If a Midical Examinar must be notified at Once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Arred Forces? 1 Yes, Give Year or Dates: W.W.II	13. Was Decedent of H If Yes, specify Cubs 1 Yes 2 No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race Black Specify:	- American Indian, k, White, etc. White
-002	thou stura		15. Decedent's Education 16a	a. Decedent's Usual Occup	pation	16	6b. Kind of Bus	siness/Industry
<u> </u>	hin 72 n "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done life. DO NOT use retired	during most of work d)	ing		,
7	d with giene grene	E O		irefighter		I	ire De	partment
ana	be file ntal Hy od othe event.	BeC	17. Father's Name (First, Middle, Last)		18. Mother's Name	e (First, Middle, Ma	aiden Sumame	a)
<u>a</u>	ould b Menta arked	To	Kenneth Veatch		Julia An	n Harriso	on	
Mar	2 sho and Is m			b. Mailing Address (Street				
ຍົ ຂົ	l and lealth m 27 her ti	1 22	3	546 Woodridg		2011		
	ges 1 If of F If ite or ot		I L Bullat ZA Cigillation 3 Lineinovalitotii State	of Disposition (Name of ery, crematory or other place	l l	ber		City or Town, State
altimor	it. Pa rtmer rtant: njury		F	field-Echols				e Hall, MD F.H., P.A.
מ	Deparenti Deparenti Importany ir	ļ.,	21. Signature of Funeral Service Licensee M0064.					Hall, MD 20622
Ü			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.					Approximate Interval Between Onset and Death
8/60,	/Medical Examiner but sicial and sicial and sicial transit the purial-transit	al Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence consequence)	of):	CAN	CER		
O. Box 6	death certifi e attending d for use as	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	h 3 □Ectopic pregnancy 5 □ Other (specify) _	у		23d. Date Mon	e of delivery tth Day Year
ds, F	w requires that the sbeen signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting DIABETES - TYPE-	in the underlying cause giv	ven in Part I.			bute to the cause of death? 3 Probably 4 ①Unknown
Hecord		Completed	ATHERO- SCLEROTIC	HEART	DISEAS	E 24a. Was an	24b. W	Vere autopsy findings available
	sician: The law certificate has birector, page 2 s	E	PERIPHERAL-VASCULAR	R DISE:		performe	ed? de	rior to completion of cause of eath? □ Yes 2 □ No
Vital	lan: rtifica	BeC	25. Was case referred to medical	1 PISE		h (Check only one))	
01 <	Q 55.	ToE	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/O	Outpatient 3 DOA	ner: 4 Nursing Ho	me 5 Residen	ce 6 □Othe	r (Specify)
	ding Ph h After th funeral			Time of 28c. Injur Injury Wor	ry at	28d. Describe how	injury occurre	d
SIO	Attendi r death ector: / by the fo	cat	2 Accident investigation		Yes 2 ☐ No			
DIVISION	in b	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, f building, etc. (Specify)	arm, street, factory, office		28f. Location (Stre City or Town,	et and Numbe State)	er or Rural Route Number,
_	Hospita 4 hours Funeral ely filler	edical Ce	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge and manner stated.	ge, death occurred at the tir and/or investigation, in my c	me, date and place, opinion, death occur	and due to the cau red at the time, dat	ise(s) and man e and place, a	ner as stated. nd due to the cause(s)
	To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of cartifier	29c. Licens		290	d. Date signed	(Month, Day, Year)
	- > - 0		V. Howanger	- D	00260	64	10-	08-2004
7	_ t_		30. Name and address of person who completed cause of death (Item 23a)					HALL, MD
	351		VIDYASAGAK ANMANGA) / - 17	17201	20	622
	Sta Regist		31. Date filed (Month, Day, Year) 32. Redistrar's Signature	land.				

Amend #2 10/13/04 per Phy AA Co. Health Dept. lo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		Registrar	1 4)			rtifica	ie or i	Dealli			Reg. No.			34005
Physici	an	Decedent's Name (First, Middle, I	_		_					2. Date of De Month	Day	()	ear	43. Time of Death
/Media	cal		rick L. Va		ef	41. 03				ectobe	r 6,	2004	-	9:50 P
Examir	ner	4a. Facility Name (If not institution, g				1		r Location of	Death		40.	County of		
unaval		Millennium at S 5. Social Security Number 6			last birthday		ewate		4 Hrs.	8. Date of Bir		nne A		deL lace (State or Fore
uneral irector		296-03-0477	1 X)M 2□F	87	Yrs.	Months		Hours	Min.	8. Date of Bir (Month, Date 2-10-1	y, Year) 917		Cour	York
		Usual Residence of Decedent				1								TOTA
a how	_	10a, State 10b. County		10c. Ci	ity, Town or L	ocation.							1	0d. Inside City Lim
89-13	Director	Maryland Anne A	rundel				water	<u> </u>			10g. Citizen of What Country?			1 🗆 Yes 2 📉
Lor 2 De nu	Die	10e. Street and Number 332 Riverside R	o.a			10f, Z	ip Code				10g. Citi			itry?
rthan "natural", or items 23a or 286-f show the Medical Examinat must be notified at	e la		12, Was Decede	et Ever in II	10 12	Was Des	2103		:-2 (0-	Specify Yes or No- 14. Race - A				
Ties and	Funeral	11. Marital Status 1 □ Never Married	Armed Force	es?	7.3.	If Yes, sp	ecify Cuba	an, Mexican,	Puerto	ecify Yes or No Rican, etc.)	,		White,	
o','e	Ď	3 ☐ Widowed 4 ☐ Divorced	d 100 es 2 If Yes, Give Year or Date	s1943_	-45	1 🗆 Yes	2₹ ₩0	Specify:				Specify: White		te
ical i	Completed	15. Decedent's	Education	1343	16a. Dece	edent's Us	ual Occup	ation			16b. Ki		f Business/Industry	
급절	ple	(Specify only highest (Specify only highest (Specify only highest (Specify only (0-12))	College (1-4	or 5+)	life.	DO NOT	use retired	during most d)	or worki			,		
	Con		4 years		Metec	rolo	gist				Fede	eral	Gove	ernment
event, I	Be	17. Father's Name (First, Middle, La	ast)							(First, Middle		n Sumame)		
marke	2	Frederick Les		leef						a Morri				
W =		19a. Informant's Name/Relationship			1					al Route Numb				
item 27 i other tre		Margaret Van Cleef/ Wife 332 Riverside Rd. Edgewater, Maryland 2 20a. Method of Disposition 1 Burial 20x Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City of Communication State												
		1 Burial 200 cremation 3		ate (cemetery, cre	matory or	other plac	´ I						
rtant njury		*4 Donation 5 Other (Specify) Kalas Crematory 10-7-04 Edgewater 21. Signatural of Funeral Service-Licensee 22. Name and Address of Facility George P. Kalas Fun								r, l	MD			
Important: if sny injury or once.		Illmetal savide	Cerisee		2	2. Name a		one T	clar	orge P. nd Rd. 1	Kala	as ru	nera	AL HOME
		23a. Part 1. Enter the disease, or co	omplications that cau	sed the deal								water	, 1111	Approximate
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item #1 per DVR. #21 per FH, G836, 10/26/04 TT

	For State II	State of Mary	land /	Department of Health and No. The Control of the Con	fental Hygienes 001.	31,006
_	Registral Pend Item	23a,pt.11,2/	per	mee fill that look to the tas	Reg. No.	34000
г	ecedent's Name (First Middle I	astl			2 Date of Dooth	O Time of Death

			1- State Unpend Item 23a, pt.II, 27 per mee	1996ate 00128 eath tas	Re	ZUUL	34006						
	Physic	an	Decedent's Name (First, Middle, Last)		2. Date of Death	h	3. Time of Death						
	/Medi		Cynthia Warren		October	13, 2004	3:57 A _M						
}	Exami	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death							
			Southern Maryland Hospital Center	Clinton		Prince	e George's						
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 M F 7. Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) Cou	place (State or Foreign ntry)						
	Director		578-72-1603 To Market Solution		12/29/	53 Wa	sh. D.C.						
	land ow		10a. State 10b. County 10c. City, Town or Lo	cation		1.	10d. Inside City Limits						
	Many -1 sh	ţ	MD PG Temple	e Hills			1. Yes 2 No						
	r 28a	Director	10e. Street and Number	10f. Zip Code	10	Og. Citizen of What Cou	A						
	h witi		3063 Brinkley Rd.#102	20748			,						
	deat	Funeral		Was Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto		U.S.A. 14. Race - Americ							
9	or He	F	1 ☐ Never Married 2 ∑ Married 1 ☐ Yes 2 ☐ No	Tes, specify Cuban, Mexican, Puerto	Hican, etc.)	Black, White, Specify: B1a							
8	72 hours after death with the Maryland naturel', or items 23e or 28e-f show alical Exactine must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 1 1 4 5 2 120 1 1 0 3 pacity:		Specify: D1a	CK						
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12	e filed within all Hygiene. I other than "remer	m d	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	_	_							
	filed y Hygie other i	e Co	17. Father's Name (First, Middle, Last)	tary Personnel 18. Mother's Name		Dept. o	f Army						
an	ld be ental ked o	0				ŕ							
2	should be nd Menta marked imatic sv	2	Harrison C. Farmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailir	Norma g Address (Street and Number or Rura	Kempe		0.43						
Maryland	0 8 8 5												
ē,	s 1 and 2 if Health item 27 l		20a. Method of Disposition 20b. Place of Dispo	Brinkley Rd.#1	UZ Tem	Oc. Location - City or To	• MEZU748						
J0	ages ant of at: If i			Mem. Cem. 10/1		Suitland,							
Baltimore,	artme orter injur			. Name and Address of Facility HO		· · · · · · · · · · · · · · · · · · ·							
ä	permit. Pages 1 Department of F Importent: If ite any injury or ot			10 SIlver Hill									
			23a. Part1. Enter the disease, or complications that caused the death. Do not ent				Approximate						
	Physician		Immediate Cause (Final				Interval Between Onset and Death						
}	/Medical		disease or condition resulting in death) a. Hypertensive Card Due to (or as a consequence of):	iovascular Disease	<u> </u>								
L	Examiner												
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68760,	ertificate be executed ding physician and se as the burial-transit	Medical	d										
×	eath certificate be executed attending physician and for use as the burial-transit	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy	30)									
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o.	0 0	iysid	1 Yes 2 No 4 Pregnant at time of death 5 L	Outer (specify)									
О.	The law requires that the death cer ate has been signed by the attendir page 2 should be detached for use	by Physician	Part II. Other significant conditions contributing to death but not resulting in the ur	derlying cause given in Part I.	23e. Did toba	acco use contribute to the	ie cause of death?						
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Be	The law	m.			autopsy	prior to cor death?	psy findings available apletion of cause of						
Vita		e C	25. Was case referred to medical	00 81 (8		No 1 XYes	2 No						
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Division of	g Phyte er this eral di	n: T	27. Manner of Dealh 28a. Date of Injury 28b. Time of	28c. Injury at 2	8d. Describe how	ce 6 Other (Specify injury occurred	7						
<u>0</u>	nding lath. r: After e funer	atio	1 Natural 5 Pending (Month, Day Year) Injury 2 Acciden investigation	Work? M 1 ☐ Yes 2 ☐ No									
Vis	l or Attend after deatl Director: I in by the	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, sire	eet, factory, office	8f. Location (Stre	et and Number or Rura	l Route Number,						
Ö	tal or s afte el Dir	Certification:	4 Homicide Stommod building, etc. (Specify)		City or Town,	State)							
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier (Check only (C	occurred at the time, date and place, a	nd due to the cau	se(s) and manner as st	ated.						
	the H iin 24 the F iplete	edical	(Check only one) 22 Medical Examiner: On the basis of examination and/or inv	estigation, in my opinion, death occurre	d at the time, date	e and place, and due to	the cause(s)						
	To with	Σ	29b. Signature and title of certifier	29c. License number		d. Date signed (Month, L	* * * *						
-			Plarol Hallan ned	O.C.M.E.	Oc	ctober 13,	2004						
			30. Name and address of person who completed cause of death (Item 23a) (Type, I										
			CHICOL H. ALLAN We	111 Penn Street,	Baltimo	re, Marylan	d 21201						
	Sta Registi		31. Date filed (Month, Day, Year) 11. Date filed (Month, Day, Year) 12. Registrar's Signature	1									
יים	MH 17 Rev 1/2		WILN U ZUU4	Sparks									
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State of Maryland / Department of Health and Mental Hydien 2001.

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Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Pr Geo Co New Carrolton 10e. Street and Number 10f. Zip Code 10g. Citizen of Wh. 6003–87th Avenue 20784 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race-	Birthplace (State or Foreign Country) Country) 10d. Inside City Limits XXYes 2 \(\) No t Country? American Indian, White, etc. Lack ess/Industry Stry te, Zip Code) 1784 y or Town, State Md PA
Examiner Facility Name (If not institution, give streat and number) County of Doctors Community Hospital Lanham, Md 20706 Pr Geo Pr G	Birthplace (State or Foreign Country) WC 10d. Inside City Limits **XXYes 2 No It Country? American Indian, White, etc. Lack ess/Industry Stry te, Zip Code) 1784 y or Town, State Md PA Md 20748 Approximate Interval Between
Social Security Number 5.5 sex 1 m/s 2 set 7. Age (in yrs. last birthday) 1 months 1 months 2 mont	Birthplace (State or Foreign Country) NC 10d. Inside City Limits **NXYes 2 No It Country? American Indian, White, etc. Lack ess/Industry Stry te, Zip Code) 1784 y or Town, State Md PA Md 20748 Approximate Interval Between
239-32-7210 1 M 28 F 75 Yrs. Months Days Hours Mn. (Month, Day, Year) Mn. 11-25-28	10d. Inside City Limits **XXYes 2 □ No It Country? American Indian, White, etc. Lack ess/Industry Stry te, Zip Code) 1784 y or Town, State Md PA Md 20748 Approximate Interval Between
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Physician / Medical Examiner Physic	PA 20748 Approximate Interval Between
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So by the second of the second	
23d. Date of pregnancy 1 FEMALE. 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown 9 Unknown 1 Unknown 1 Unknown 1 Unknown 1 Unknown 23d. Date of Month 2 Sh. Was decedent pregnancy 1 Yes 2 No 9 Unknown 9 Unknown 1 Unknown 1 Unknown 2 Sh. Was decedent pregnancy 23d. Date of Month 2 Sh. Was decedent pregnancy 1 Yes 2 No 9 Unknown 9 Unknown 1 Un	
T a T a G	delivery Day Year
Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributions of the conditions of the conditions contributions of the conditions contributions to death but not resulting in the underlying cause given in Part I.	**
1 Yes 2 No 31	Probably 4 Unknown
9 3 9 9 A HITERED MENTAL STATE 24a. Was an 24b. Was	autopsy findings available to completion of cause of
The special sp	
1 Yes 2 No Hospital: patient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other 2 27. Manger of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred	Specify)
The state of the s	
building, etc. (Specify) City or Town, State)	r Rural Route Number,
29a. Certiflier (Check only one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner and manner stated.	
29b. Signature and title of certifier 29d. Date signed (A 10/9)	due to the cause(s)
R (5) VENEURS NEQUESTIE, MD, 11115pring Street, Swite 214, Silverspring	due to the cause(s)
State 31. Date filed (Month, Day, Year) Registrar's Signature	onth, Day, Year)

State of Maryland / Department of Health and Mental Hygien ? 1 14

	1	For State Registrar	State of Mary	land / Depa <i>Cer</i>	irtment of H tificate of I	lealth and M Death		en2004	34008
&		1. Decedent's Name (First, Middle, Last)	-			2. Date of Death Month	Day, Apar	3. Time of Death
Physic /Medi		Craig	Watson				October	7 2004	5:14 Р м
Examil		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of Death	
	1, 32	2203 Ohio Avenue	1 - 4		Landove	er If Under 24 Hrs.	S. Data of Birth	Prince Ge	
Funeral		5. Social Security Number 6. Se	X 2 F 7. Age (In	yrs. last birthday)	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birth	olace (State or Foreign
Director		219-86-6398 Usual Residence of Decedent	31	0			January 6	6 1968 Wasl	iington, De
land ow		10a. State 10b. County	100	c. City, Town or Lo	cation				10d. Inside City Limits
Mary -1sh	to	MD Prince G	eorge's	Land	lover				1 ⊠Yes 2 □ No
r 288	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Cou	ntry?
th with	ai D	2203 Ohio Avenu	e		2078			U.S.A.	
ems err	Funerai	11. Marital Status	12. Was Decedent Ever Armed Forces?	r in U.S. 13. \	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
or it	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give		1□Yes 2፟፟INo	Specify:		Specify: B1.a	eck
hours	q p	3 Widowed 4 Divorced 15. Decedent's Edi	Year or Dates:	16a Deced	dent's Usual Occup	ation	16	6b. Kind of Business/Ir	dustry
n 72	Completed	(Specify only highest grad	de completed)	(Give	kind of work done on DO NOT use retired	during most of work	king		
d withi	duo	Elementary/Secondary (0-12)	College (1-4or 5+)	Mai	1 Clerk			Government	
Hygin other	BeC	17. Father's Name (First, Middle, Last)					e (First, Middle, Ma	aiden Sumame)	
ld be lenta rked tic ev	To B	James A. Watson				Bessie	Jones		
Idn yidning Z 1Z 12-00000 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or flems 23a or 28a-f show aumatic event, the Medical Examinating the retified at	[19a. Informant's Name/Relationship (7	ype, Print)				ral Route Number, (City or Town, State, Zi	o Code)
and 2	1	Bessie Watson/Mo			Box 8855	-	Virginia		
of He		20a. Method of Disposition 1 ♣ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Dispo cemetery, cres	natory or other place	ce)	Date 20	oc. Location - City or T	own, State
Pag ment tent:		'4 □ Donation 5 □ Other (Specify)	Church C		10-1		illwyn.Vir	
DESILITIOTE, INICITY INITY ALL INTENDED. PERMIT. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinating the notified at any injury or other traumatic event, the Medical Examination and once.		21. Signiflure of Funeral Servin Licen	see					ns Funeral	
40540		23a. Part1. Enter the disease, of compshock, or heart failure. List only	lightions that caused the	death Do not ent	er the mode of dur	on such as cardiac	or respiratory arres	, Maryland	Approximate
Pnysician /Medical Examiner		shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a. Sickle Ce Due to (or as a co	ell Disea onsequence of):					Interval Between Onset and Death
Hecords, P.O. Box b8/bu, The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	dical Examine	rr any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a co						
S, F.O. BOX of es that the death certific igned by the attending p be detached for use as i	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of deliv Month	ery Day Year
uires that uires that signed by	ğ	Part II. Other significant conditions o	ontributing to death but n	not resulting in the u	inderlying cause giv	ven in Part I.		acco use contribute to s 2 ⊠No 3 ☐ Pro	the cause of death? bably 4 □Unknown
of Vital Records Physicien: The law require this certificate has been sign al director, page 2 should b	Completed						24a. Was an autopsy perform	prior to c	opsy findings available ompletion of cause of
tal nn: T tifficat tor. pi	(a)	25. Was case referred to medical				26. Place of Dea	th (Check only one		
ysici ysici is cer direct	To B	examiner? 1 ☐ Yes 2 [2] No	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatie	nt 3□ DOA Ott	her: 4 🗆 Nursing H	ome 5 Residen	nce 6 Other (Spec	fy)
ng Ph ter th		27. Manner of Death	28a. Date of Injury (Month, Day Y	ear) 28b. Time o	of 28c. Inju	ry at rk?	28d. Describe how	v injury occurred	
DIVISION OF VITAL HECOFIAS, To the Hospital or Attanding Physician: The law requires to within 24 hours after death. To the Funerel Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be	Certification;	1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined	n	- At home, farm, st]Yes 2 □No	28f. Location (Stre City or Town,	eet and Number or Rui State)	al Route Number,
DIV To the Hospital or A within 24 hours after To the Funeral Dire complately filled in by	edical C	29a. Certifier 1⊠ Certifying Pr (Check only one) 2□ Medical Exam	ysician: To the best of r niner: On the basis of ex and manner stated	camination and/or in	th occurred at the tinvestigation, in my	me, date and place opinion, death occu	, and due to the cau irred at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
To th withir To th	W	29b. Signature and title of certifier	Mol	a.M.	1 DOO	se number 12-86	3 29	d. Date signed (Month	2
\$ 10		30. Name and address of person who Hassan A. Mola	vi M.D. 600	5 Landove	r Road St	uite 1 Ch	everly, M	aryland 20	785
7 3	tate	31. Date filed (Month, Day, Year)	32. Hegistrar	s Signatur					

		For Unpend Item Registrar 1. Decedent's Name (First, Middle, Las		Cer	uncale or	Death 335	2. Date of Dea	th	104	34009 3. Time of Death	
Physic /Medi		PHILLIP MAR	K WOOD				Octobe	r 17	2004	2028 P ^N	
Exami		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death			ounty of Death		
		Doctors Community			Lanham	1.11.1			ince Ge		
Funeral Director		355-52-2661	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day May 13	, _{Year)} 1958	9. Birth Cou I111i	place (State or Foreig ntry) nois	
land DW		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loc	ation			10d. Inside City			
Marylan -1 show iied et	to	MD Prince	George's	New Ca	rrollton				1y∑ Yes		
h tha or 28a e routi	Director	10e. Street and Number	0 -		10f. Zip Code		1	l 0g. Citizen of What Country?			
23a c		5917 89th Avenue			20	784		U.S.A	Α.		
er des	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	l M	as Decedent of H Yes, specify Cuba	ispanic Origin? (Sp ın, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14	Race - Ameri Black, White		
U.SO ours after death with the Maryla al', or Items 23a or 28a-1 shov Executors the notified at	by F	1 ☐ Never Married 2 ★ Married 3 ☐ Widowed 4 ☐ Divorced	1 ⊡Yes 2□NoAir: trYes, Give Year or Dates:	rorce 1	□Yes 2. XNo	Specify:		s	pecify: B	lack	
IL Z I Z I 3-UU30 filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or Items 23e or 28e-1 show int, the Medical Exercipe trust by notified at	ted	15. Decedent's Ed (Specify only highest gra	ucation	16a. Deced	ent's Usuat Occup	ation	ina	16b. Kind	of Business/Ir	dustry	
ithin and and and and and and and and and an	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of work f)					
LING A I A ba filed within tal Hygiene. Id other than event, the M		12th 17. Father's Name (First, Middle, Last)		Sales	s Manager	18. Mother's Name		Priv			
g da ga ga	To Be	Nathaniel Wood Sr	•			Tommie		малдел St	ımame)		
re, Maryla s 1 and 2 should f Health and Men Item 27 is marks othar traumatic		19a. Informant's Name/Relationship (7						er, City or Town, State, Zip Code) on, Marvland 2078			
Paga a		Montina I. Wood/Wife 5917 89th Avenue New Carrol 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)							20c. Location - City or Town, Sta		
0 40		1 ☐ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify	Removal from State	emetery, crem	atory or other plac	e)					
Daltimo permit. Page Department Important: It eny Injury o		21. Signature of Funerat Service Licen				tery 10-1				Maryland	
		1- M				ver Road					
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the death	. Do not ente	r the mode of dyin	g, such as cardiac	or respiratory arr	est,	ır y ranu	Approximate Interval Between	
executed executed by sician and the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence. Due to (or as a consequence)								
The law requires that the death certifica the law requires that the death certifica ate has been signed by the attending propage 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Tyes 2 No 9 Unknown	23c. If yes, outcome of pregnar 1□Live birth 2□Fetal 4□Pregnant at time of de 9□Unknown	death 3 🗌	Ectopic pregnancy Other <i>(specify)</i>			230	d. Date of deliver	ery Day Year	
quiras that n signed t	þ	Part tl. Other significant conditions co Diabetes mellitus	ontributing to death but not resu	iting in the un	derlying cause give	en in Part I.				he cause of death? pably 4 Unknow	
The faw requir	Completed						24a. Was a autops perform	n 2 y ned? 2 \(\) No	24b. Were auto prior to co deatr? 1 Yes	psy findings availab mpletion of cause of	
ding Physician: The h. After this certificate funeral director, pag	Be	25. Was case referred to medical examiner?	11			26. Place of Death	n (Check only on	e)	/		
Phys this o	P.	1 X Yes 2 □ No 27. Manner of Death		ER/Outpatient 28b. Time of		4 Nursing no	me 5 Reside			y)	
	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	28c. Injury Work	(? Yes 2 □ No	Zod. Describe no	iw injury o	ccurred		
nding th. : After s funer	Certification:	3 Suicide 6 Could not be determined		me, farm, stre	et, factory, office		28f. Location (St. City or Town		lumber or Rura	I Route Number,	
LIVISION OF VICAL NECOLUS, tel or Attending Physician: The law requirast is after death. al Director: After this certificate has been signed in by the funeral director, page 2 should be	Ç	20a Cartifica 4 Cartifulas Phy	d manner as s ace, and due to	tated. the cause(s)							
he Hospital or Attending in 24 hours after death. ha Funeral Director: After blately filled in by the funer	edical Ce	29a. Certifier 1 ☐ Certifying Phy (Check only offer Check on the Check of Check on the Check of Check on the	and manner stated.				29d. Date s			signed (Month, Day, Year)	
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical Ce	(Check only 2 Medicel Exem	and manner stated.		29c. License	number	2	o. Date s	igned (Month,	Day, Year)	
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral completely fi	edical	One 2 Medicel Exem	and manner stated.			number			er 18,		
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral completely filled in by the funeral completes.	edical	29b. Signature and title of certifier	and manner stated.		O.(Octob	er 18,	2004	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiepen 0 1 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Wilson October 0 2004 12:15 AM 6 Yolanda /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Prince George's Cherry Lane Nursing Home Laurel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | JUNE 11 1960 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1[]_M 2[]XF Yrs. Director 577-86-5614 VIRGINIA Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examples in must be notified at 1 Yes 2 □ No Director PRINCE GEORGES MITCHELLVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 908 LAKEFRONT DRIVE U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 XNo Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: Black. 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Private 12th MANAGER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be GEORGE FRANCIS B TAYLOR WILSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20774 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 FRANCIS B TAYLOR/MOTHER 10135 PRINCE PLACE # 202 UPPER MARLBORO, MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ₩ <u>₩</u> 1 ₹8urial 2 TCremation 3 Re ò permit. Page Department of Important: If RESURRECTION CEMETER 10/15/04 injury ' 4 ☐ Donation 5 ☐ Other (Specify) SUITLAND , Maryland 22. Name and Address of Facility J. B. Jenkins Funeral Home 21. Signature of Funeral Service Licenses 7474 Landover Road Landover, Maryland 20785 23a. Part1. Enter Part1. Enter the discuss, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metastatic Breast Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to (or as a consequence of): Examiner Tany Isading to Inmedicause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 X Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate ! 1 Yes 2**½** No 1 Yes or Attending Physician: filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 XNo Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death 2 🗌 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2 0

Division of Vital Records, P.O. Box 68760,

Baltimore. Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

051051

October 7, 2004

			1 - For State Registrar	State of M	aryland / Depa <i>Cei</i>	artment of H <i>rtificate of L</i>			en2004	34011
	Dhuaisi		1. Decedent's Name (First, Middle, Li	ast)				2. Date of Death Month		3. Time of Death
	Physici /Medio		RONALD	Р.	WRIGHT	7		OCTOBER	10, 2004	12:46P. M
	Examir	er	4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town, or	Location of Death		4c. County of Dea	th
			NORTHWEST Hospita 5. Social Security Number 6.		je (In yrs. last birthday)	RANDALI If Under 1 Year	STOWN If Under 24 Hrs.	9. Date of Righ	BALTIMOF 1967 9. Bir	
	Funeral Director		216-98-7880	1½0 M 2□F 36		Months Days	Hours Min.	8. Date of Birth (Month, Day, December		thplace (State or Foreign ountry) ryland
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show Trivel be notified at	tor	MD Prince	George's	Upi	oer Marlbo	oro			1⊈Yes 2□No
	th the	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
	238 c	alD	3104 Geaton Dri	ve			20774	U	.S.A.	
		Funeral	11. Marital Status	12. Was Decedent Armed Forces?		Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	
36	8 5 E	by F	1 XNever Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No	1□ Yes 2⊠ No	Specify:		Specify: R1	ack
8		ted t	15. Decedent's E	ducation	16a. Dece	dent's Usual Occupa	ation	11	6b. Kind of Business	
215	i within 72 ho piene. r than "natur the Medical	ple	(Specify only highest gi	ade completed) College (1-4or	(Give	kind of work done of DO NOT use retired,	turing most of workir)	ng		,
7	filed within Hygiene. Ither than "	Completed	12th			lunteer			Private	
Maryland 21215-0036	b d la b	Be	17. Father's Name (First, Middle, Las				18. Mother's Name			
<u> </u>	should be and Mental I marked o	70	Stanford A. Wri	0	10h Maili	on Address /Chroste		Hendrick	S City or Town, State,	7: 0 ()
Ma			Miriam Wright/M	. , . ,						
<u>6</u>	s 1 ar f Hea item other		20a. Method of Disposition		20b. Place of Dispo	sition (Name of matory or other place	D		o Mary Lan Oc. Location - City or	
Ë	Page nent o nt: if		1 X Burial 2 ☐ Cremation 3 [`4 ☐ Donation 5 ☐ Other (Spec		1	National	1	5-04 I	Laurel, Mar	ewland
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		21. Signature of Funeral Service Lice	onsee	1 / 22	2. Name and Addres	s of Facility J.	B. Jenk	cins Funer r, Maryla	al Home
			23a. Part 1. Enter the disease, or dor shock, or heart failure. List on	nplications that cause						Approximate
	Physician		Immediate Cause (Final disease or condition	one cause on each I	1 :	ection				Interval Between Onset and Death
7	/Medical		resulting in death)	Due to (or as	a consequence of):	egivii				
	Examiner		Sequentially list conditions,	b						
	pe isi	lne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or minny that initiated events	Due to (or as	a consequence of):					
	xecut and	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):					
68760,	rcate be executed physician and the burial-transit	edlcal E		d						
	tificat ng phy as th									
Вох	eath certifi attending for use as	by Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		Ectopic pregnancy			23d. Date of de	,
E	at the dea by the at tached fo	/slcl	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant a 9□ Unknown	t time of death 5	Other (specify)			Month	Day Year
ط	that the ed by detac	Phy	Part II. Other significant conditions	contributing to death b	out not resulting in the u	nderlying cause give	en in Part I	23e. Did toba	cco use contribute to	the cause of death?
Records,	The law requires that the death certificate be executed to has been signed by the attending physiclan and page 2 should be detached for use as the burial-transit					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		1 □ Yes	1.7	robably 4 Unknown
000	e law re has bea	Completed						24a. Was an autopsy	24b. Were at	utopsy findings available completion of cause of
Ä	G 17	Com						performe 1 1 Yes 2	ed? death?	
Vital	Physician: The Is this certificate ha ral director, page 2	Be (25. Was case referred to medical examiner?			1	26. Place of Death			
of	this ald	٦.	1X Yes 2 □ No 27. Manner of Death	Hospital: Inpatie			4 🗀 Nulsing Hon		ce 6 □Other (Spe	cify)
- Lo	une une	tlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ury 28b. Time of Injury	Work	at (? (es 2 □ No	8d. Describe how	injury occurred	
Division	Attending or death. ector: After by the funer	fica	3 ☐ Suicide 6 ☐ Could not l	28e. Place of Ini	jury - At home, farm, str		- 12	8f. Location (Stre	et and Number or Ri	ural Route Number
Ö	al or / s after il Dire d in b	Certification:	4 Homicide determined	building, et	c. (Specify)	,,,		City or Town,	State)	, real or real
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the ft	edical	29a. Certifier 1 Certifying P (Check only one)	hysician: To the best miner: On the basis o and manner st	of my knowledge, death	n occurred at the tim vestigation, in my op	e, date and place, a pinion, death occurre	nd due to the cau ed at the time, dat	se(s) and manner as e and place, and due	s stated. to the cause(s)
	o the	Me	29b. Signature and title of certifier	and manner of	atod.	29c. License	number	290	1. Date signed (Mont	h, Day, Year)
	~ > ~ O		Descript An	HALL MI		0.C.	M.E.		TOBER 11,	
	inex	N	30. Name and address of erson who	completed cause of	death (Item 23a) (Type,	Print)				
	TR I		Pamela E. E	outhay, M	D	111 Penn	Street, E	Baltimore	e, Marylan	d 21201
	Sta Regista		31. Date filed (Month, Day, Year) 20	04 3 Registr	rar's Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 4 34012 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Eleanor Catherine Wiggins 11:18A October 0 8 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner E1kton
If Under 1 Year If Under 24 Hrs. Union Hospital 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year)

Feb. 22, 1914

PA 7. Age (In vrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 ☐ M 2 🕅 F Days Hours 90 Director 222-24-3917 Usual Residence of Deceden filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28a-1 ehow item 27 is marked other than "naturel", or Items 23s or 28s-1 show other traumatic event, the Movidal Examinar must be notified at Director 1 ☐ Yes 2 🕅 No MD Ceci1 Chesapeake City 10e. Street and Number 10g. Citizen of What Country? 280 Hollywood Beach Rd. Completed by Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2 ☐ Marned Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ➡ No Specify: 3 Novel 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Housewife Household 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be I of Health and Mental I Pages 1 and 2 should be ဂ္ John Solonski Catherine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 280 Hollywood Beach Rd., Betty Beckley/Daughter Chesapeake CityMD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 0 1 □ Burial 2 IXCremation 3 □ Removal from State October permit. Page Department of Important: If any injury or * 4 ☐ Donation _ 5 ☐ Other (Specify) Ferris Inc. 13,2004 West Chester, PA 21. Signature of unava Sprvice Licenses 22. Name and Address of Facility Andrew G. Gee Funeral Home 23a. Part1. Entry the disease, or complications that caused the death. Do not enter the mile of hying, such as cardiac or respiratory arrest, mendiate Court (Texture 1) and tailure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final **Physician** 11A(/Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner death certificate be executed the attending physician and hed for use as the buriat-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the a should be detached t 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by C 2 X No 1 Tyes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 has autopsy rmed? 2.X.No certificate 1 ☐ Yes or Attending Physician: luneral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Medical Certification: To 28a. Die of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Salatural 5 Pending investigation within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident the f 6 Could not be determined 3 Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie To the 29b. Signature and title of dertifier 29c. License number 29d. Date signed (Month, Day, Year) 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Timoth Peuples PlyZA 32 DONNYU to UU, Hewnk 19702

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

1 2 2004

32. Registrar's Signat

			Please Type or I	Print in Black	Indelible Ink	. Ensure A	All Copies	Are Legible.			
			State of Sta	Maryland / De	epartment of I Certificate of		,	giene 2004	34013		
FIF	Physici		Decedent's Name (First, Middle, Last) James Roland Willia				2. Date of Dea	Day Year	3. Time of Death 4:05 p M		
	/Medio Examin		4a. Facility Name (If not institution, give street and nun		4b. City, Town.	or Location of Deat	10 - 0	07 - 2004 4c. County of Deat			
	Exami	eı	Southern Maryland Hospit	1	Clint						
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthe	day) If Under 1 Year	If Under 24 Hrs	8. Date of Birt	h 9. Birti	George's hplace (State or Foreign		
	Director		577-64-4263 1™ 2□F Usual Residence of Decedent	58 Yr	rs. Months Days	Hours Min.	8. Date of Birt (Month, Da) 03-03-	1946 Wash	ington, D.C		
	yland		10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits		
	Mar B-f st	ţo	D.C.	Was	shington				1ÆYes 2☐No		
	th the	irec	10e. Street and Number		10f. Zip Code	·-		10g. Citizen of What Co	untry?		
	th wi	Funeral Director	1923 Summit Place, N.E.		2	20002		U.S.A.			
	ems ems	ne	11. Marital Status 12. Was Dece Armed Fo	dent Ever in U.S.	13. Was Decedent of If Yes, specify Cub	Hispanic Origin? (S	pecify Yes or No-	14. Race - Ame			
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "netural", or Items 23s or 28e-f show any injury or other treumatic event, I'm Medical Examinations is be institled at once.	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes If Yes, Giv Year or Da	2 □ No e	1 ☐ Yes 2 No		, 510.,	Black, White, etc. Specify: black			
5-0	72 h	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. D	ecedent's Usual Occu Give kind of work done	pation during most of wo	rkina	16b. Kind of Business/	,		
21	vithin ne. han	ld m	Elementary/Secondary (0-12) College (1	-4or 5+)	ife. DO NOT use retire	ed)		St. Elizabe	th		
	filed w Hygiel other ti		12th	Shee	et Metal Me		(S. 1. 14)	Hospital			
and	be fi	Be	17. Father's Name (First, Middle, Last)					Maiden Surname)			
Maryland	should nd Men marke umatic	T _o	Thomas E. Williams, Sr. 19a. Informant's Name/Relationship (Type, Print)	10h h	dailing Address (Ctross	Dorothy		- Ch F Ch 3	F. O. I. I.		
Ma	d 2 s th an th an treur		Yvonne L. Williams Rooks	/Sister 192	23 Summit P	lace, N.	rai Houte Numbe	r, City or Town, State, Z	up Code)		
	of Health Item 27 i		20a. Method of Disposition	20b. Place of D	shington, Disposition (Name of	l.	Date	20c. Location - City or	Town State		
<u>0</u>	ages int of t: If It		1 Burial 2 □ Cremation 3 □ Removal from S	State Quantico	Crematory or other plantional Center National	10-1	18-04	Triangle, V			
Baltimore,	permit. Pages Department of I Importent: If Its any injury or of		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	rary tan				Funeral Ho	-		
Ba	Depar Impo any ir		Manda C. Baron		D.C. 2001	•					
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
	Physician		Immediate Cause (Final	OS : C					Interval Between Onset and Death		
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	and trans	Examiner	that initiated events c.								
60,	be executed sician and burial-transit	al E)	Due to (or as a consequence of)):						
687	leath certificate attending physi	dice	d								
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o.	The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	Physician/Medic	1 Yes 2 No 9 Unknown 9 Unknown								
U.	res that igned b	by P	Part II. Other significant conditions contributing to de	-	, , ,			bacco use contribute to	the cause of death?		
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SCO	law requas been 2 should	plet	ACUTE RENAL PAIL	URE. AT	VEMIA		24a. Was a		topsy findings available		
Vital Records,	The tay ate has bage 2	Completed	HYPERTENSION, D	ABETES	MELLI	TUS	autop: perfor	med? death?	ompletion of cause of 2 No		
ita	ilcien: The certificate rector, pag	ВеС	25. Was case referred to medical examiner?	K 150 1 = 3			th (Check only or				
of <	Physic this ce al dire	일	Hospital:	patient 2 ER/Outp	atient 30 DOA		ome 5 Resid	ence 6 Other (Spec	ufy)		
ū	ding Physicien: The in the interpretation of the interpretation of the funeral director, page		27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month	of Injury 28b. Tim h, <i>Day Year)</i> Inju	iry Wo		28d. Describe h	ow injury occurred			
<u>s</u>	tend feath tor: /	cat	2 Accident investigation 3 Suicide 6 Could not be			Yes 2 □No					
Division	after of Direct of In by	ertification:	determined 206. Flave	of Injury - At home, farm ig, etc. (Specify)	n, street, factory, office		28f. Location (S City or Tow	treet and Number or Rui n, State)	ral Route Number,		
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	edical C	29a. Certifier 1 Certifying Physicien: To the Check only 2 Medicel Exeminer: On the base	isis of examination and/o	death occurred at the ti or investigation, in my o	me, date and place	, and due to the c rred at the time, c	ause(s) and manner as date and place, and due	stated. to the cause(s)		
	o the ithin 2 or the or the or the or the	Med	20h Signatur and title of partition	er stated.	and Linear			29d. Date signed (Month			
	F 3 F 8		ATTENDI	NG PHYSI		52900		i0-09-2			
0	1 (.)		30. Name and address of person who completed cause	e of death (Item 23a) /T-		, , ,					
	4 U		8700 CENTRAL AV.	H301 L	LANDOVER	MI	2078	35			
	Sta Registr		31. Date filed (Month, Day, Year) OCT 1 2 2004	egistrar's Signature	and the						

State of Maryland / Department of Health and Mental Hygier 2004 34014

		- 1	- State Amend 10D, perFH, FCHD, SL, 10/Ce/Oficate of D	eath	Reg	. No.	07017
			1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physicia		CHARLENE MARIE WHITEN		Month October	8,2004	12:08 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or U	ocation of Death	000001	4c. County of Deat	
	LXamii	٠,	Frederick Memorial Hospital Frederic	ck		Frederi	ck
	Funeral		Months Dave	If Under 24 Hrs. Hours Min.	8. Date of Birth	Q Rie	hplace (State or Foreign
	Director		212-50-9718 1 M 2 F 56 Yrs. Months Days	Hours Min.	July 23	1948	Md.
7	2		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Location				1404 1-14-00-11-1
	anytar show	_	10a. State 10b. County Md. Frederick Frederick				10d. Inside City Limits
	ith the Maryland or 28a-f show	cto					
	or 2	늞	10e. Street and Number 4836 East Basford	7/707	10g	Citizen of What Co	ountry?
	ath w	Funeral Director	, 0 3 0	21703	-7. V N	14. Race - Ame	don Indian
	after dea or items	n n	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 12. Never Married 2 Married 1 Yes 2 No	, Mexican, Puerto F	Rican, etc.)	Black, Whit	
5	l', or	by F	3 Widowed 4 Divorced Year or Dates:	Specify:		Specify: B/	ack
9500-c	n 72 hours after death with the Maryland "natural, or items 23a or 28a-f show avical Examinar must be motified at		15. Decedent's Education 16a, Decedent's Usual Occupat	ion	16	b. Kind of Business	Industry.
2	within 7; ene. than "n	ple	(Specify only highest grade completed) (Give kind of work done du life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)		19	rederich	h County
7	d with	Completed	lyr. Teachers	aide	_<	school b	Board
<u> </u>	be filed tal Hygi d other event,	Be		18. Mother's Name			
yland		10	Charles W. Whiten, Sr.	Betty L	DIXON	1	
Mary	2 should and Men is marke aumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street ar	nd Number or Rura	Route Number, C	ity or Town, State,	Zip Code)
e, z	s 1 and f Health item 27 other tr	ļ	tugene Henderson (friend) 4836 East				
≒			20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)) [1.0	c. Location - City or	
Ĕ	Pages ment of l ant: If it		'4 □ Donation 5 □ Other (Specify) Farriter Cem.	Oct. 12,	2004 F	rederick	e, ma.
Baltimor	permit. Page Department of Important: If any injury of once.		21. Signature of Funeral Service Ligensee Pullin 22. Name and Address Gavy L. Rollin 110 West S.	of Facility	ral Home		.7.5.4
п	⊈0 = e		Muy X. Kollin 110 West S	outh st	Frederick	md. 2	
			23a. Part1. Enter he disease, of complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line.	, such as cardiac o	r respiratory arrest	•	Approximate Interval Between Ønset and Death
, 1	Physician		Immediate Cause (Final disease or condition August	EMMORL	1466		WEEK
	/Medical Examiner		resulting in death) Due to (or as a consequence of):		-		
	Examine:	_	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	ed sit	lne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
_	certificate be executed ding physician and ise as the burial-transit	Examiner	that initiated events c				
9	be e iician buria						
09/89	icate phys s the	/Medical	0.				
×	nding use a	√Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of del	livery
ň	atten afor u	clar	in the past 12 months?			Month	Day Year
o.	the c y the achec	Physicia	1 Yes 2 No 9 Unknown 9 Unknown				
ر ح	The law requires that the death Ite has been signed by the atter bage 2 should be detached for i	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	n in Part I.	23e. Did tobac		the cause of death?
Records,	quire n sig				1 ☐ Yes	2 X No 3 □ Pr	robably 4 Unknown
00	s been signatured should b	Completed			24a. Was an	24b. Were au	itopsy findings available
	he la e has age 2	Hi0			autopsy performe	d3 death?	completion of cause of
Vita		a	25. Was case referred to medical	26. Place of Death		140 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2010
	Attending Physician: or death. ector: After this certific by the funeral director,	o B	examiner? 1 Yes 2 No Hospital: Inpatient 2 ER/Outpatient 3 DOA Other	-		ce 6 □Other (Spe	cify)
0	g Phys er this eral dii	n: T	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury	at 2	28d. Describe how	injury occurred	
0	ath. rr: After	atlo		es 2 No			
Division of	or Attend after death Director: A	tiflo	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	2	28f. Location (Stree City or Town, S	et and Number or Ru State)	ural Route Number,
ā	spital or Ai ours after o neral Directilled in by	Certification:					
	tospi hou uner uner	edical	29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time (Check only 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opi	e, date and place, a	and due to the caus	se(s) and manner as	s stated.
	To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in by	ledi	one) and manner stated.				``
	To Toon	Σ	29b. Signature and title of certifier 29c. License	16675		Date signed (Monti	4
•			00,70	100/3	C	CT. T	2004
	5		30. Name and address of person who combleted cause of death (Item 23a) (Type, Print) WAYNE ALLGAIER 60 GHA AVE: BRUNSW	iel mi	1. 7/7/1	l o	
			WAYNE ALLGAIER VOIO HAN AVE BRUNSW 31. Date fled (Month, Day, Year) 32. Registrar's Signature	CCR /IV	V 1111		
	Sta Registi		OCT 12 2004 Denve & Span	61			

DHMH 17 Rev 1/2001

State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier [] For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 3. 10 AM WON 06 10 BOK 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Clevery County Howard Columbia Howard | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept 20, 1 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 6. Sex 5. Social Security Number Months 1 ☐ M 212 F 88 1916 Korea None Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 Yes 2X No Directo MD Howard Ellicott City 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21043 8782 Manahan Drive Korea by Funerai 14. Race - American Indian, Black, White, etc. 12, Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: 3€ Widowed 4 Divorced Asian Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ring most of working Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker Own Home 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be unknown unknown 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8782 Manahan Drive Ellicott City, MD 21043 Mi Ok Lee/Granddaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 10-9-2004 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Catonsville, MD 22. Name and Address of Facilit Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):

permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. important: if item 27 is marked other them any injury or other traumation. **Physician** /Medical Examiner

Funeral

Director

28a-f show

ŏ

or items 23a

death

other traumatic event, the Madical Examiner must be notified at

Physician/Medical Examiner þ Be Completed ဥ Certification:

29a. Certifier

use as the burial-transit and signed by the a page certificate After Medical

or Attending Physician: The law requires that the death certificate be executed

Box 68760.

P.O. 1

Records,

Division of Vital

To the Hospital or missing within 24 hours after death.

To the Funeral Director: After the Funeral Director of the fur State

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide

(Check only one)

6 Could not be determined

5 Pending investigation

Lacertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

MD

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea

1 Impatient

28a. Date of Injury (Month, Day Year)

9 Unknown

4☐Pregnant at time of death

2 Fetal death

2 ER/Outpatient

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

D0053709

3 Ectopic pregnancy

3 DOA

М

28c. Injury at Work?

29c. License number

1 ☐ Yes 2 ☐ No

5 Other (specify)

Y d Bowie mn

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month. Dav. Year)

23d. Date of delivery

Month

23e. Did tobacco use contribute to the cause of death?

20 No

1 TYes

rmed? 2 ☑ No

28d. Describe how injury occurred

24a. Was an autopsy perform

1 🗌 Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

Day

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3060 CHAWLA mitchellville Raj

Hospital:

31. Date filed (Month, Day, Year)

ann

32 Registrar's Signature

A 38461

Registrar

State of Maryland / Department of Health and Mental Hygien 10 1

For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 58 Year **Physician** CHOBER Lonnie A. ALston 21,2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deathy Examiner Greneral MURC Ryand If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1**∑**M 2□ F Months Min. 97 Yrs. 03-14-1907 Director 242-05-1554 South Carolina Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ?) is marked other than "natural", or items 23a or 28a-f shov traumatic event. The Worldal Examinar must be notified at 1 X Yes 2 No Baltimore Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 3229 Massachusetts Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. illed within 72 hours after 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specify: ð 3 ☐ Widowed 4 1 Divorced **Black** Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 in and Mental Hygiene.
7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Security Night Watchman 6 land 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elica Abell Charlie J. ALston 2 Maryl 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3229 Massachusetts Avenue Balto, MD 21229 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 Peggie A. Bell item 27 more. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or of once. 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State 10-29-04 Lansdowne, MD Mt. Zion Cemetery 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signature Funeral Service Licenses 22. Name and Address of Facility Bai Wylie Funeral Home 638 N. Gilmor St. Balto, MD 21217 art1. Enter the disease, if comshock, or heart failure. List only complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause in each line. Approximate Interval Between Onset and Death neumonia Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Dusito (or as a consequence of): cause. Enter Underlying Cause (Disease or injury Examine V. executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) 68760, physician eq. Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy ó in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) o. the detached þ مَ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ pe 4 Unknown 1 Yes 2 No 3 Probably page 2 should Completed peen 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No has certificate 2 **P** No Vital director, 25. Was case referred to medical 26. Place of Death (Check only one, examiner: 2 ER/Outpatient 3 □ DOA Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 2 No this funeral 28c. Injury at Work? Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t Certification: Division or Attending 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after of Funeral Direct filled in by 4 - Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29b. Signature and title of cartifler 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kenneth Geh, M.D. 90 MA 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State OCT 2 Registrar

State of Maryland / Department of Health and Mental Hygien 2004 1 - For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Cora Elizabeth Antal October 0 24, 14:30 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. Cily, Town, or Location of Death **Examiner** 4c. County of Death 201 Prospect Mill Road Bel Air Harford 7. Age (In yrs. last binhday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 XF 160-20-8299 Yrs. Director Dec. 30, 1924 Pennsylvania Usual Residence of Decedent the Maryland 10b, County 10a. State 10c. City, Town or Location item 27 is marked other than "naturel", or items 23a or 28a-f show other traumatic event, the Modical Example and inust by modified at 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 201 Prospect Mill Road 21014 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. should be filed within 72 hours after of Mental Hygiene. marked other than "naturet", or itel 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: 3 ₩ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pennsylvania Elementary/Secondary (0-12) College (1-4or 5+) Manufacturers Association 12 Compensation Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi and Mental H Be Mark William Rich Mildred (unk) Grove 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 l Daneene A. Lucas / Daughter 201 Prospect Mill Rd., Bel Air, MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of H Important: If ite any injury or ot once. 1 XBurial 2 ☐ Cremation 3X Removal from State 5 Other (Specify) Crown Hill Cemetery 10-29-04 4 Donation Twinsburg, Ohio 21. Signature of Lineral Service Licensee McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23al Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** C HYDNIC REGIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner INSETES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) physician and the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, STRUIGE 1 Yes 2 No 3 Probably 4 ☐Unknown Be Completed U ROSANSUS page 2 s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No performed? 212 No 1 ☐ Yes Hospitel or Attending Physicien: director 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ZÑo Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural s after dec. 5 Pending investigation 1 □Yes 2 □ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only onel within 2 To the I 29b. Signature and tale of certifies 29c. License number 29d. Date signed (Month, Day, Year) D 22843 OCTOBER ZT, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R. PHILLIPS 2005 MOCIC SPRING FURIST HILL and 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 2 7 2004 Registrar

			For State Registrar	State of Ma	aryland	d / Depa <i>Ce</i>	artment of F	lealth a Death	and Me		giene	004	34019
	Physici	an							2. Date of De. Month	onth Day Year			
	/Medic	ai	4a. Facility Name (If not institution, give s.				4b. City, Town, o	r Location	of Death	Octobe		2004 unty of Death	5:47 A M
	Examin	er	Gilchrist Center	in oot and warmen,			Towson		OI DOGUI			altimo:	re Co.
	Funeral Director		5. Social Security Number 6. Sex 218-92-3787 1⊠	M 2□F 26		as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. 8 Min.	3. Date of Birt (Month, Da June 2	th y, Year)	9. Birthp	place (State or Foreign http)
	pu .		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	neation						
	Manyla f shor	ŏ			Too. Only	, 1041101		ndalk					10d. Inside City Limits 1 ☐ Yes 2€2No
	28a-	Director	Maryland Balt 10e. Street and Number	imore			10f. Zip Code		_		10g. Citizen	of What Cour	ntry?
	th with	al D	7922 Kavanagh Roa	d				2122	2		United	d State	es
36	be filed within 72 hours after death with the Maryland hat Hygiene. So other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be motified at	by Funeral	11. Marital Status 1 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give			Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Ori an, Mexicar Specify:	n, Puerto Ri	ify Yes or No ican, etc.)		Race - Americ Black, White, ecify:	etc.
Ö	tural	ed b	15. Decedent's Educ	Year or Dates:		16a, Dece	dent's Usual Occup	ation				Whof Business/In	nite
AM. 21215-0036	hin 72 In "ne	Completed	(Specify only highest grade		(4)	(Give	kind of work done DO NOT use retired	durina mos	it of working	7	TOD. KING C	n business/iii	uustiy
	er the	Com	12 Years		,,,	Dis	abled				N,		
5:47 Maryland	be filk	Be	17. Father's Name (First, Middle, Last)						,	First, Middle,		,	
∑ SZ	hould d Mer marke	2	James F. Bennett 19a Informant's Name/Relationship (Type	na Print)		10h Maili	ng Address (Street			ine M.			0-4-1
Mar.	lth an 27 ls r traui		Mrs. Josephine Be	•	ther		Ravanag			ndalk,			21222
B S	s 1 er	4.7	20a. Method of Disposition		20b. PI	lace of Dispo	sition (Name of matory or other place	(e)	Da	te	20c. Locati	on - City or To	own, State
Ë	Page nent c ant: If ury or		1X Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State			of Faith		10/25	/2004	Rose	edale,	MD
Baltimore,	permit. Pages 1 end 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 is marked other than any injury or other traumatic event. Ite Magnes.		21. Signature of Funeral Service License	θ			2. Name and Addre Ouda-Ruck 1922 Wise						nc. .222
77	100		23a. 11. Enter the disea of complication shock, or heart failure. List only on	cations that caused e cause on each lin	I the death								Approximate Interval Between
	Physician	11	Immediate Cause (Final disease or condition	SARC	COMA	+							Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequ	ience of):							
-7	1.50	e	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequ	ience of):							
¢	ansit and	Examiner	Cause (Disease of knjury that initiated events										
(I) (S)	icate be executed physicien and s the burial-transit	Exa	resulting in death) Last	Due to (or as	a consequ	ience of):							
2BE F 68760,	cate b physic the b	edical	d										
OCIO Box 6	ath certif attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	Bc. If yes, outcome 1□Live birth 4□Pregnant at	2 Fetal	death 3	Ectopic pregnancy Other (specify)				23d.	Date of delive	ery Day Year
1 Q	at the de by the a	hys	9 Unknown	9□ Unknown									
-	w requires that been signed t should be det	by	Part II. Other significant conditions con	tributing to death b	ut not resu	ulting in the u	nderlying cause giv	en in Part I		23e. Did to	\ \		ne cause of death?
GENNET	e law re has bee ge 2 sho	Completed					_			24a. Was		b. Were auto	psy findings available impletion of cause of
	The ate h	Com								perfo	rmed?	death?	
i3€ Vital	Physicien: The this certificate he	Be	25. Was case referred to medical examiner?	nenital:			045			Check only o			
> 10	는 부 등	tion; To	1 Yes 2 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatie 28a. Date of Inju (Month, Da		ER/Outpatier 28b. Time o Injury	f 28c. Injur Wor	4 🗆 NU	28	5 ☐ Resid d. Describe h		Other (Specificurred	nospice
E FFRE Division	or Attending after death. Director: After din by the fune	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injuding, etc	ury - At ho c. (Specify	me, farm, str	reet, factory, office		28	f. Location (S City or Tou	Street and Nu vn, State)	umber or Rura	il Route Number,
7	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	edical C	29a. Certifier Certifying Phys	ician: To the best er: On the basis of and manner sta	f examinat	wledge, deat ion and/or in	n occurred at the tin vestigation, in my o	ne, date an pinion, dea	nd place, an occurred	d due to the o	cause(s) and date and plac	I manner as si ce, and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	^			29c. Licens	e number			29d. Date sig	gned (Month,	Day, Year)
			> your	krus			DS	83 C	3		000	sel ?	7 2004
644	17		30. Name and address of person who could have the charges	mpleted cause of d	leath (Item	23а) (Туре	Print	57	Bu	ltine	Ne W	D 212	204
	Sta Registr	-	31. Date filed (Month, Day, Year) OCT 2 7 2004	32, Registr	ar's Signat	Lure	Sparks	,					

State of Maryland / Department of Health and Mental Hygien 001, 34020 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Bessie Helen October 23, 2004 2:23 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Gilchrist Nursing Center Baltimore Co. Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2874F Yrs. Director 007-18-5403 April 8,1923 Maine Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits ral', or Itams 23a or 28a-f ehow Examiner must be notified at Maryland Baltimore 1 ☐ Yes 2√√No Director Dunda1k 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? with 1962 Eastfield Road 21222 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 1 TNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Completed by Specify: 3 Widowed 4 □ Divorced "natural" White ar than "natur. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Ith and Mental Hygien 27 is marked other th traumatic event, The 12 Years Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ukn VanScyoc ပ Pauline Bradley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health : Mr. Bradley Baker Son 2301 Smith Avenue Landsdowne, Maryland Itam 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State = 5 permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) St. Mary Cemetery 10/26/2004 Baltimore, Maryland 21. Signature Fulleral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 23 7922 Wise Ave. Dundalk, Maryland 21222 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician AIVWAY Chronic years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of). Examine Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of): burial-1 Box 68760. physician Physician/Medicai the IF FEMALE esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 4□Pregnant at time of death Month Day Year 5 Other (specify) ed by the a detached f P.O. 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed: 2 No 1 🗆 Yes 2 No 1 ☐ Yes Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 KOther (Specify) 1 ☐ Yes 2 XNo Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 XNatural 2 ☐ Accident 5 Pending after death. Diractor: A 1 ☐ Yes 2 ☐ No investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 24 hours a Funaral I 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainter as stated. (Check only onel within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 25205 no October 25, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balto. 6 BMC N. Chriles 6701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

7 2004

State of Maryland / Department of Health and Mental Hygiene 2004 34021 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Thomas J. BURNS October 20,2004 1032A M /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 603 Lanoitan Road Apt. H
 H
 Middle River

 7. Age (In yrs. last birthday)
 If Under 1 Year Months | Days | Hours | Min.
 Baltimore 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** DE M 2 D F Yrs. Director 216-72-7428 Maryland Feb. 6,1959 Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 27 is marked other than "naturel", or items 23s or 28s-f show traumatic event, the Modical Examiner must be notified at 10d. Inside City Limits 1 Yes 2 No Maryland Middle River Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 603 Lanoitan Road Apt. H 21220 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2F No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 □ Never Married 2 □ Married 3altimore, Maryland 21215-0036 þ 1 ☐ Yes 2 No Specify. Specify: White 3 ☐ Widowed 4 StDivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Motor Repair Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Mechanic Electric 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental P be Thomas A. Burns Margaret Francis Kanyekski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Thomas A. Burns/Father 603 Lanoitan Road Apt. H Middle River, MD Health item 27 i 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o 1 ☐ Burial 2√2Cremation 3 ☐ Removal from State Hilltop Service Corp. 10/23/2004 Towson, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licena 22 Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 3a. art1. Enter the disease, o shock, or heart failure. Lis Approximate Interval Between Onset and Death Immediate Cause (Final ulmonary Physician disease or condition resulting in death) 5 years /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (ur as a consequence of): certificate be executed burial-transit attending physicien and for use as the burial-trar resulting in death) Last Due to (or as a consequence of) 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 1 been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Completed 1 Yes 2 No 3 Probably 4 Minknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred After 1 Natural To the Hospitel or Attending within 24 hours after death.
To the Funeral Director; Afte completely filled in by the fun 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 018667 October 22,2004 30. Name and address of person who completed cause of deat (Item 23. (Type, Print), Philip Mil 31. Date filed (Month, Day, Year) Trumble Hill CT. Lutherville, MD 21093 MILLTELLO MD 6 32, R strar's Signature State

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Registrar

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			For Stata Registrar	State o	f Ma	ryland / De	partme <i>ertifica</i>			nd M	,	gien Reg. N	22-1	31.022
	Physici		1. Decedent's Name (First, Middle	e, Last) Franc	is	Charles	Barr	ett			2. Date of De Month Octobe	D	year 20,2004	3. Time of Death 10:10 P ^M
	/Medic Examin		4a. Facility Name (If not institution	n, give street and nu	mber)		4b. City	, Town, or	r Location of	Death	OCCODI		c. County of Death	
			Gilchrist Cen	ter				To	wson				Ba lti	more Co.
	Funeral		5. Social Security Number	6. Sex 1 🖫 M 2 🗆 F		(In yrs. last birtho	Months	r 1 Year Days	If Under 24 Hours	Min.	8. Date of Bir (Month, Da	ay, Yea		place (State or Foreign intry)
	Director		213-07-1425 Usual Residence of Decedent		8	6					April 8	8,19	918 Mary	land
	laryland show		10a. State 10b. County	Da 14 day		10c. City, Town o	r Location		na					10d. Inside City Limits
	D after death with the Maryla or Items 23a or 28a-1 shor	cto	Maryland	Baltimo	ore.				Edgeme	ere				1 Tyes 2 No
	with the a or 2	Dire	10e. Street and Number 8106 Penwood .	Λιονιο			10f. Z	p Code	21219			_	Citizen of What Cou	
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Ş	ural',	d by	3 🕱 Widowed 4 □ Divorced	Year or E	ates:									White
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1	Baltimore, permit. Pages 1 ar Department of Hea Important: if item any injury or other		21. Signature of Funeral Service				22 Name	nd Addre	se of Facility				ndalk, In	
	n 88558	1	1/2	a	4						dalk,			1222
			23a: Part 1. Enter the disease, o. shock, or heart failure. List	complications that	caused t each line	9.			-				1 1	Approximate Interval Between Onset and Death
	Physician /Medical	ĺ	Immediate Cause (Final disease or condition resulting in death)	a	Ng	1ple	ural	Car	CER	po	basle r	nes	otheliong	years
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ج :	DIVISION or Attending after death. Director: Attention tin by the fune	ifica	3 Suicide 6 Could	not be 28e. Place		y - At home, farm				-			and Number or Rur	al Route Number,
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	2		30. Name and address of person	ves m	se of de	ath (Item 23a) (T	horse		T Beil	tim	we mo	2	1204	
	Sta Regist		31. Date filed (Month, Day, Year OCT 2 7 20	104 Se	Registra	's Signature	Spa	Kr						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 34023 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 3:07 PM Caroline E. Benner 2004 /Medical 4a. Facility Name (If not institution, give street and number)

Mariner Health of Bel 4b. City, Town, or Location of Death Examiner County of Death めもし Hartoro 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Yea Aug. 19, 9. Birthplace (State or Foreign **Funeral** Year) 1935 Maryland 1 □ M 2000 220-30-5511 69 Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral, or iteme 23a or 28a-f show Examiner must be notified at MD Harford Abington Director 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after deeth with 21009 508 Eastview Terrace Apt.2 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: à SpecifyWhite 3 Widowed 4 Divorced "natural" Completed ir than "nature 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry MAryland Cup Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator Ith and Mental Hygier 27 Ie marked other the traumatic event, Inc. Corporation 6th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Heelth and Mental H tant: If itam 27 le marked off lury or other traumatic even Emil Blische Rosalie Cook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 508 Eastview Terrace Apt. 2 Abington MD Rosalie Pretty /daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State SacredHeartofJesus 10/27/04 Baltimore permit. Page:
Department of
Important: If i
any injury or
once. ' 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility ConnellyFuneralHomeofEssex 300 Mace Ave.Baltimore MD 21221 23a. Part 1. Enter the disease, an implications that caused the shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Paget and Death Immediate Cause (Final disease or condition resulting in death) **Physician** esperatory ways /Medical Due to (or as a consequen of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1. X Natural 1 ☐ Yes 2 ☐ No Accident Director; d in by the 6 Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funaral C completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) -0018779 30. Name and address of person who completed cause of death (Item 23a) (Type Print)

Albert S., Sun, M.D. 1716 Harford Road, Ste. 105. Fallston MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2004

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day October 24, 2004 Virginia Baugham Year 143 pm 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Millenium Franklin Square Baltimore Hours Min. 8. Date of Birth (Month, Day) 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Maryland 1 □ M 2 🕅 F Months Days Year) 579-16-6090 73 Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Baltimore 1 Yes 2 □ No MD NA 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1217 Favette Street USA 21201 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1X Never Married 2 ☐ Married ☐ Yes 2 🕅 No f Yes, Give 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: Year or Dates: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LTRICOVIT 16b. Kind of Business/Industry unknown 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) unknown 17. Father's Name (First, Middle, Last) unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Floyd/ Guardian 300 Metro Plaza Baltimore, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 10-27-04 Lansdowne, MD 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home 638 N. Gilmor St. Balto, MD 21217 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DUEUMONIA DAYS Due to (or as a consequence of) Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 3 ☐ Probably 4 ☑ Onknown 1 ☐ Yes 2 ☐ No RETARDATION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 210 No 1 Tes 1 ☐ Yes 2 No 26. Place of Death (Check only one)

Physician /Medical Examiner In records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

rthen "neturel", or items 23e or 28e-f ehow the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours efter deat Department of Health and Mental Hyglene. Important: If item 27 is marked other the any injury or other trainers.

Directo

Funeral

Be Completed by

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within 24 hours e To the Funeral C completely filled Hospital

or Attending Physicien:

efter death

Division of Vital Records, P.O. Box 68760,

Examiner Physiclan/Medical ģ Completed Be Certification: To neral Director: A

25. Was case referred to medical examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

29a. Certifier (Check only

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature end title of certifier

DOU 584 57

OCTO BER 2064

29d. Date signed (Month, Day, Yeer)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

NATIVAL CEASAGE 621 NEUTAW STREET, BAUTIMORE 31. Date filed (Month, Day, Year)

State Registrar

Medical

32. Registrar's Signature Seem & Spark

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** October 25, 12:45pm[™] 2004 Maryellen Burns /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Carroll Hospital Center Westminster If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Aug 26, 1 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 ₽ F Yrs. PA 219-34-4405 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State r Items 23a or 28a-f show 1 ☐ Yes 2 ☐ No MD Sykesville Completed by Funeral Director Carroll 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7200 Third Avenue 21784 USA 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after cannot of Health and Mental Hygiene.
nn: If item 27 is marked other than "neturel; or liter
ury or other traumatic event, I'm Madical Experiment 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ Xo Specify: Specify: White Baltimore, Maryland 21215-0036 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Bennett Thompson Henrietta Cardwell 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Maryellen Fisher (Daughter) 701 Wimmer Road Glen Burnie. Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Importent: If ite
any injury or ot
once. 1 Durial 2 Cremation 3 Removal from State Prospect Hill Cemetery 10/29/04 Towson, MD 22. Name and Address of Facility
HAIGHT FUNERAL HOME & CHAPEL, PA (Bound of Sykesyille, MD 21784 (410) -795-1400

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 4 ☐ Donation 5 ☐ Other (Specify) PA (Box 195) Approximate Interval Between Oneet and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit K that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ed by the attended for us 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To 1 Tyes this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deat To the Funerel Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier completely (Check only one) the 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Center Drive ushnur 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2004 Registrar

Rag. No. 0 0 4 State of Maryland / Department of Health and Mental Hygiena 34026 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death oct. 24,2004 **Physician** Year 9:00A. N Elnora Benvenga /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 2527 Eastern Avenue NA 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF 78 Director 220-18-7358 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-1 show other traumatic event, the Medical Examiner must be notified at Maryland Baltimore 1 XYes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2527 Eastern Avunue 21224 U.S.A. itеms 23¢ 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ☐Yes 2 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 X No Specify: White 2 If Yes, Give Year or Dates: 3 Widowed 4 Divorced natural 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainmett. Elementary/Secondary (0-12) College (1-4or 5+) Computer Operater Fort Holabird 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mary Frank Buck Gorecki 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis Benvenga Jr./ 2527 Eastern Avenue Baltimore, MD 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State MD Veterans Cem. ' 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills, MD 10 - 28 - 0421. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph N. Zannino Jr. Funeral Home 263 S. Conkling Street Balto. Md 21224 23a. Part1. Enter the disease, shock, or heart failure. L or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit and The law requires that the death certificate be execu Due to (or as a consequence of): Box 68760, attending physician Physician/Medical as the l IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy Įo in the past 12 months? 1 ☐ Yes 2 🖾 No Month Dav 4☐Pregnant at time of death 5 Other (specify) Records, P.O. the detached 9□ Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ be OREILION O JIEO ALTHUT 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ZNO 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No. of Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home ပ 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) Sign funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred ion: After Division 1 Natural 2 Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation Certificat in by the 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 24276 10-25-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIMON , SCALIA Md. 2801 HUDSON ST. BAUTIMONE, MD 21224 31. Date filed (Month, Day, Year) OCT 2 7 2004 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygie 20 0 4

Certificate of Death

Reg. No.

34027

		1 - For State Registrar 1. Decedent's Name (First, Middle, Last)	State of Maryla	Cei	rtificate of E	Death		eg. No.	34U21	
Physi		The bookdark of reality (1 real, rendered, 2004)	Robert L	ee Bea	rd		Month	Day Yea ct 24, 2004		
/Med Exam		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Death		4c. County of De	eath	
		Blue P	oint Nursing Hom	е		Balti	more		N/A	
Funera Directo	_	217-346251	M 2 T F	rs. last birthday) 67 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day May 4,	9. E 1937	Sirthplace (State or Foreign Country) Maryland	
faryland ahow	5	Usual Residence of Decedent 10a. State 10b. County Maryland N/A		City, Town or Lo		ltimore			10d. Inside City Limits 1 Yes 2 □ No	
vith the A	Direct	10e. Street and Number			10f. Zip Code			0g. Citizen of What	Country?	
eath v	erai	11 West 20th Street #2D	12. Was Decedent Ever in	1115 121	Was Decedent of His	21218	nocity Vac or No		merican Indian,	
Dallillore, Mary Jianio Z. 1.2.10-0000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f ahow any injury or other treumatic event, the Neulical Experiment for hydified of	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cubar 1☐ Yes 2 1 No	Specify:	o Rican, etc.)	Black, W		
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within he.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	(DO NOT use retired DO NOT use	borer		Cons	struction	
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Maryiand od 2 should be file th and Mental Hy 27 Is marked oth		19a. Informant's Name/Relationship (Ty) Catherine Harthfield	oe, Print)	1	ng Address (Street a			, City or Town, State	, Zip Code)	
s 1 ar		20a. Method of Disposition		b. Place of Dispo	sition (Name of natory or other place	.)	Date	20c. Location - City	or Town, State	
Page nent o		1 ဩ Burial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cometery, crea	Mt. Zion	"	10/28/04	Landsdow	n , Maryland	
Dallillore, permit. Pages 1 a Department of Hee Important: If item any injury or othe		21. Signature of Funda Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Hon 1300 Futaw Place Baltimor						lome P.A. nore, MD 21217		
		23a. Part I. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the de	eath. Do not ent					Approximate Interval Between	
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A dentification of the property of the propert	/Med	IF FEMALE:	3c. If yes, outcome of pre	ananay				1		
es that the death certigned by the attendin	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown 2 3 Ectopic pregnancy 23d. Date of Month 2 State 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown							lelivery D ay Year	
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To the within To the comp	Me	29b. Signature and title of certifier RAUM K	Balrit M	. D	29c. License			9d. Date signed (Mo		
A		30. Name and address of person who co	mpleted cause of death (I	Item 23a) (Type	Print)					
	tate	XAMON L BOWitt	32. Registrar's Sig	gnature 2		1 *	Le (2)C 2	700/	V 01136	
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ORIGINAL

		1 - For State of Maryland / Depart	tment of H		Mental Hy	/giene	04	34028		
Dhysisis		Decedent's Name (First, Middle, Last)		-	2. Date of D Month		Year	3. Time of Death		
Physicia /Medica		CHAPLES		BREON			2004	4-13 A M		
Examine	r	4a. Facility Name (If not institution, give street and number)	b. City, Town, or	Location of Dea	7 -1	4c. Co	unty of Death			
		5. Social Security Number 6. Sex 7. Age (in yrs. last birthday)	1 N /+ I M D If Under 1 Year	If Under 24 Hrs	174	inth	N/A			
Funeral Director		160-36-5213 10XM 2 F 62 Yrs.	Months Days	Hours Min	. (Month, D	ay. Year) 2, 194	2 Poun	place (State or Foreigr intry) SYLVANIA		
		Usual Residence of Decedent			Sejore.	2, 177	z renn	sycounce		
arylan show	_	10a. State 10b. County 10c. City, Town or Local						10d. Inside City Limits		
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with the Marylan a or 28a-1 show be notified at		10e. Street and Number P.O. Box 276	10f. Zip Code	16804		10g. Citizen of What Country?				
death with the Maryland ms 23a or 28a-1 show rmust be notified at	Funeral		s Decedent of Hi		Specify Ves or N		S.A. Race - Ameri	can Indian		
	두	Armed Forces? If Y	s Decedent of Hi		to Rican, etc.)	14.1	Black, White,			
3 % - 3	2	3 ☐ Widowed 4 ☐ Divorced If Yes, Give ☐ 1959 ☐ 1☐ Year or Dates: 1963]Yes 2∭XNo	Specify:		Spe	acify: W	hite		
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es 1 g		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition cemetery, cremati	on (Name of		Date		on - City or T	own, State		
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Dallimore permit. Pages 1 Department of H Important: If Ite any injury or ott		21. Signature of Funeral Service Licensee 22. N	lame and Addres	s of FacilityS C	rimunek	Funera	l Home	S		
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		23a. Part1. Enter the disease, or complications that caused the death. Do not enter t shock, or heart failure. List only one cause on each line. Immediate Cause (Final	the mode of dying	g, such as cardia	c or respiratory a	arrest,		Approximate Interval Between Onset and Death		
Physician /Medical		disease or condition resulting in death) a. FUNGAL PNEUMONI. Due to (or as a consequence of):	A					O DAYS		
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The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	alcai	d								
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tal or Attending P rs after death. el Director: After t led in by the funera	25	4 ☐ Homicide determined building, etc. (Specify)			City or To	wn, State)				
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Viti	2	29b. Signature and title of certifier	29c. License			29d. Date sig	ned (Month,	Day, Year)		
	-	MAINT MD	D0058	5902		CTOBER	19,	2004		
1011	- 1	30. Name and address of person who completed cause of death (Item 23a) (Type, Prin		CTORET	0 4 7 44 4	C MAA	1 - IP	2227		
State		31. Date filed (Month, Day, Year) 32. Registrar's Signature		- FEE	DAL (1 POP	BANTA	LAND	21287		
Registra	r	DCT 2 7 2004 Shows B	parks							

John Birkmaier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

04	-6870		For State Registrar	State of Ma	aryland / Depa	rtment of Hi tificate of L	ealth and M Death	ental Hygi	2004	34029	
			Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death	
	Physicia /Medic		John Joseph Birkmaier						Month Day Year 10/23/04		
	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death						4c. County of Deat				
			Franklin Square Hos		e (In yrs. last birthday)	Rosedalo	If Under 24 Hrs.	8 Date of Birth	Baltimo		
	Funeral Director			1 2□ F 7. A9	48 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, June 24	1956 Ma	hplace (State or Foreign untry) LYLand	
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits	
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	r 28a	irec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?	
	238 o	ai D	18 Gunview Farm C	ourt			21128	3	u.s.A.		
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If items 23a or 28a-f show If itam 27 is marked other than "netural", or items 23a or 28a-f show or other traumatic event, the Markeal Examinal Trust be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced	Was Decedent Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:	No I	Was Decedent of Hi f Yes, specify Cubar 1 ☐ Yes 2 X No	spanic Origin? (Spe n, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.	
21215-0036	n 72 hc	Completed	15. Decedent's Educa (Specify only highest grade	completed)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	ition luring most of workii)	ng 1	6b. Kind of Business	Industry	
12	within liene.	omp	Elementary/Secondary (0-12)	College (1-4or :	5+1	ect Manag			Shipping	Company	
nd	12 should be filed within hand Mental Hygiene. 7 is marked other than "raumatic event, the Mental Hygiene.	BeC	17. Father's Name (First, Middle, Last)	· / p:./			18. Mother's Name				
Maryland	ould to	1º	John Joseph Freder				Emelia		ller	Zin Cado)	
Mar	d 2 sh th and 7 is rr traurr		Mrs. Ruth C. Birkmo						City or Town, State, . LL, MD 211		
	ss 1 and 2 of Health itam 27 i		20a. Method of Disposition		20b. Place of Dispo				Oc. Location - City or		
OH	Pages nent of int: If it		1 XBurial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	moval from State		Cemetery		/2004 B	Baltimore,	Maryland	
Baltimore,	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licenses		22	2. Name and Addres	s of Facility Sch	imunek F	uneral Hom	ies	
8	89189		23a, Part 1. Enter the disease, or complic	elle					e, MD 2123	6 Approximate	
	Prysician /Medical Examiner	ner	shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, any, issuing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Cardiov Due to (or as	ascular Distance of the aconsequence of the ac	c Arrthmi sease	a bac to	Acres of	Terocic	Onset and Death	
8760,	cate be executed physicien and the burial-transit	dical Examin	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as	a consequence of):						
9			IF FEMALE:								
O. Box	The law requires that the death certifit to has been signed by the attending to age 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year	
4	w requires that the bean signed by should be detact	by	Part II. Other significant conditions cont	ributing to death I	out not resulting in the u	inderlying cause give	en in Part I.		acco use contribute to		
I Records,		Completed						24a. Was ar autops perform	y prior to ned? death?	utopsy findings available completion of cause of 2 No	
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital: (_/.		ot 30 DOA Oth	26. Place of Death	Section of the section of			
of	Phys r this rat di	- T	1 Yes 2 No 27. Manner of Death	1 V Inpati		III 3LI DOA	4 Littershing 1 to		nce 6 Other (Spe w injury occurred	icify)	
lon	Attanding Frideath. Sector: After	tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of Inj (Month, Da	aý Year) Injury		k? Yes 2□No				
Division	in Line	27. Manner of Death 1 K Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Imme of Injury Work? 1 Yes 2 No 28c. Nlury at Work? 1 Yes 2 No 28e. Place of Injury At home, farm, street, factory, office building, etc. (Specify)							reet and Number or R , State)	ural Route Number,	
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the bes er: On the basis and manner s	t of my knowledge, deal of examination and/or in tated.	th occurred at the tin	ne, date and place, pinion, death occurr	ed at the time, da	ate and place, and du	e to the cause(s)	
	Totl withi Totl comp	W	29b. Signature and title of certifier	(29c. Licens			od. Date signed (Mon October, 2		
			30. Name and address of person who con	npleted cause of	death (Item 23a) (Type	, Print)					
			Ana Rubio, MD 31. Date filed (Month, Day, Year)	111 32. Red	trar's Signature		ore, MD 2	21201			
	Si Regis	ate trar	OCT 2 7 2	004	en &	porte					
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Please Type or Print in Black Indelible Ink.	Ensure All Copies	Are Legible

		1	State of Maryland / Department of Health and Certificate of Death	mentai Hy	Reg. No.	004 34030
		_	Decedent's Name (First, Middle, Last)	2. Date of D Month	eath Day	3. Time of Death
	Physicia /Medic	al .	EDWARD THOMAS CRENSHAW, JR. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deat	Octob		2004 1853 M
	Examin	er	4a. Facility Name (If not institution, give street and number) STELLA MARIS at MERCY HOSPITAL BALTIMORE	11	40.0	ounty of Bouth
	Funeral Director		5. Social Security Number 449-70-7964 6. Sex 7. Age (In yrs. last birthday) 6. Sex 7. Age (In yrs. last birthday) Months Days Hours Min.		irth Pay, Year) 1943	Birthplace (State or Foreign Country) MICHIGAN
	pue *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Maryli f sho	ţō	MD ANNE ARUNDEL PASADENA			1 ☐ Yes 2 X X o
	ith the	Olrec	10e. Street and Number 10f. Zip Code			on of What Country?
	sath w	Funeral Director	7862 KINGS BENCH PLACE 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (5 ff Yes, specify Cuban, Mexican, Puer	Specify Yes or N		4. Race - American Indian,
36	be filed within 72 hours after death with the Maryland tal Hygiene. Ide Hygiene. Ide other then "neturel", or Items 23e or 28e-f show event, the Medical Examinar must be mailfied at	þ	1 Never Married **Twarried 1 X Yes 2 No If Yes, Give 1 Yes 2 XXNo Specify: Year or Dates:	to Rican, etc.)		Black, White, etc. Specify: WHITE
21215-0036	72 hou	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work done	orking	16b. Kind	d of Business/Industry
121	within iene. then "	ompi	Elementary/Secondary (0·12) College (1·4or 5+) 12 College (1·4or 5+) LOGISTICIAN		HAR	RIS CORP.
	e filed al Hygie other vent, I	e l	17. Father's Name (First, Middle, Last)	me (First, Midd	le, Maiden S	Sumame)
ylar	should be nd Mental marked o	To B	EDWARD THOMAS CRENSHAW, Sk. SIDEE		har Cihrar	Tourn State 7in Code)
Maryland	2 sh and is m		19a. Informant's Name/Relationship (<i>Type, Print</i>) ANN CRENSHAW — WIFE 7862 KINGS BENCH PLAC			
	s 1 and if Health item 27 other to		20a. Method of Disposition 20b. Place of Disposition (Name of	Date UNK		ation - City or Town, State
<u>ii</u>	Pages ment of I ent: If ite ury or o		XXBurial 2 □ Cremation 3XXemoval from State 4 □ Donation 5 □ Other (Specify) DELEON CEMETERY	MADWI AND		EON TEXAS
Baltimore,	permit. Pages Department of I Importent: If ite eny injury or of once.		1.96 CDATH HICHRIAN			TUARY SUPPORT
			KELLY GREGORY FINK #M01148 426 CRAIN HIGHWAY 23a. Part1. Enter the classes, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Pnysician		shock, or heart fature. List only one cause on each line. Immediate Cause (Final disease or condition			Onset and Death
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.O. Box	ne death certiff the attending thed for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		- 23	3d. Date of delivery Month Day Year
<u>α</u>	n requires that fhe de been signed by the should be detached	b	Pat II, Other significant content of the same state of the same st		d tobacco us □ Yes _2/2	se contribute to the cause of death? No 3 Probably 4 Dunknown
Records,	e lav has	Completed		ре	as an topsy rformed? s 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
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of Vital	Phys rthis ral dii	1: To	1 Yes 2 No 1 Inpatient 2 Ervoutpatient 3 DOA 4 Not sing	28d. Describ		Other (Specify)
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Division	s after de safter de si Directo	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		n (Street and Town, State)	d Number or Rural Route Number,
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical (29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and pla 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pla 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pla 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pla 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pla 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pla 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pla 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pla 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pla 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pla 3 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pla 3 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pla 3 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pla 4 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and the t	ce, and due to to curred at the time	e, date and	place, and due to the cause(s)
	To the within 2 To the complex	Me	29b. Signature and title of certifier 29c. License number 2408541		29d. Date	a signed (Month, Day, Year)
-	111,		30 Name and address of person who completed cause of death (Item 23a) (Type, Print)		2120	7
	\ 	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	md.	2120) —
	Regis					

State of Maryland / Department of Health and Mental Hygien 0 0 L 34031 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** CLARK October 2004 6:06 A JAMES /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Baltimore Perring Parkway Center Genesis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JUNE 28, 19 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) 5 Social Security Number **Funeral** Hours Months Days 1**X** M 2□F June Yrs. Maryland 82 Director 213-18-6381 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County items 23a or 28a-1 show other traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Director Baltimore Maryland N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U. S. A. 21213 4022 Balkern Avenue Completed by Funeral 14. Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Item sny injury or other traumatic access. Anned Folces: 1 Myes 2 □ No If Yes, Give Year or Dates 1943 – 1945 1 ☐ Never Married 2 X Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) US Postal Service Clerk 12th Grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Roxanne Elwell James L. Clark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4022 Balfern Avenue, Baltimore, Maryland 21213 Evelyn R. Clark (Wine) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 10/26/2004 Baltimore, Maryland Bayview Crematory 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 3331 Brehms Lane, Bactimore, Marykand 21213 (e-1 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Meson **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year jo in the past 12 months? 5 Other (specify) 4 Pregnant at time of death ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No 1 ☐ Yes Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 2 of 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Division To the Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD 314 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) onto 13alt 314M1 821N SHOAI 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

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State Registrar

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15 32. Registrar's Signature 31. Date filed (Month, Day, Year)

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

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of person who c 10

30. Name and addre

omplet cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene 2004 1 - For State Registrar 34033 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 9.10 AM Castleman October Thelma 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Kandallstown Northwest Hospital Cemer BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 10/21/1921 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MD **Funeral** 1 ☐ M 2 🛱 F Months 83 212-16-6094 MD Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show treumstic event, the Medical Exercities must be notified at BALTIMORE PIKESVILLE 1 ☐ Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or itams 23a or 725 MT. WILSON LANE 21208 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. be filed within 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: Specify: WHITE 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 □ Divorced "naturel', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) OCCUPATIONAL THERAPIST MEDICAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental h Pages 1 and 2 should be ment of Health and Menta JACOB KESSELMAN BLAUSTEIN IDA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GAIL CASTLEMAN / DAUGHTER 5 GALA LANE PIKESVILLE, MD 21208 other t 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any njury or once. 6 BETH TFILOH CONG. 10/26/2004 WOODLAWN, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Fugeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Aspiration pneumonia 96 hours /Medical Due to (or as a consequence of) Examiner Jourgaenie Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nsequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Certification: To Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Month Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) should be detached the 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 ☐ Probably 4 ☐ Unknown Dementia 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 2 No Osteoporosis vascular disease Yes or Attending Physicien: 25. Was cas referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA his 28a. Date of Injury (Month, Day Year) neral Director: After the filled in by the funeral 28c. Injury at Work? 27. Magner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral (Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D28462 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Center Randallstown, Maryland 21133 Vorthwest Hos 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygien 2004 34034 1 - State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 139 A M DEBORAH COLLINS 2004 GAIL OCTO DER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BEL AIR MARFORD YPPER CHESH PEAKE MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M **20X**F Months 46 Director 215-76-3668 MARCH 9 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified a 1 Yes 2 No Director MARYLAND BALTIMORE CO CHASE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with Items 23a 11825 EASTERN AVENUE 21220 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced BLACK "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th grade RETAIL SALESPERSON GOODWILL INDUSTRIES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be should be fi and Mental F FLOYD COLLINS GLORIA HUGHES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 l Cheryl Lee Wiggins/Daughter 601 Longwood Ct., Edgewood, Maryland 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages
Department of I
Importent: If it
any injury or o n State 2 ☐ Cremation 3 ☐ Removal from State '4 □ Donation 5 □ Other (Specify)

21. Signature of un transfer to the second of the HOLLY HILLS MEMORIAL 10-29-04 MIDDLE RIVER, MARYLAND 22. Name and Address of Facility
WM C BROWN COMMUNITY FUNERAL HOME-HARFORD, P.A. dealler 321 S PHILADELPHIA BLVD., ABERDEEN, MD 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tmmediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** 56. usn'illy introncition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) O. 9☐ Unknown 9 **Unknown** Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Vascular 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 20 No 1 Yes 1 Yes or Attending Physician: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 X ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation after deat 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de To the Funeral Directo completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month. Day, Year) 29c. License number 29b. Signature and title of certifier mo14206 pleted cause of death (Item 23a) (Type, Print) BALTO Md 21222 UKNA MU, DIME 32. Registrar's Signature State Registrar

Collins, Deborah

State of Maryland / Department of Health and Mental Hygiener 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 21, 2004 **Physician** MARK TODD CHIVERAL 1103 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Dundalk Baltimore 875 Jay Dee Avenue If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 10/2/78 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 MM 2 □ F MARYLAND 26 600-07-2548 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a State 10d. Inside City Limits Iteme 23a or 28a-f ehow rer must be notified at 1 ☐ Yes 2 No Director BALTIMORE DUNDALK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 879 JAY DEE AVENUE 21222 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: Specify: 3 Widowed 4 Divorced WHITE the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LABORER HANDY MAN traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CARL CHIVERAL TERESA RICE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MRS. TERESA BINKO/ MOTHER 6710 HUDSON ST. BALTIMORE, MD. 21224 Item 2 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. BAYVIEW CREMATORY 10/25/04 BALTIMORE, MD. ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee KACZOROWSKIFacifUNERAL HOME P.A. EuloT (DUNDALK AVE. BALTIMORE, MD. 21222 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Shotgun **Physician** iontact Wound of Head disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ğ Month Dav 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. gue 1 Yes 2 No 3 Probably 4 Yunknown Be Completed page 2 should 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? death? 1 Yes 2 🗆 No 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Nother (Specify) At Scene Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes 2 No 28a. Date of Injury (Month, Qay Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural Injury 5 Pending 21/04 after death. Director: A 11:03 PM 1 ☐ Yes 2 No subject shot self investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office outside building, etc. (Specify)
875 Jay Dee Ave — 28f. Locath (Street and Number or Rural Route Number, City or Town, State) filled in by 875 Jay Dee Ave BaltimareHD 24 hours a Funeral (1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 ho To the Fun completely t (Check only onel 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 22, 2004 completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month Coay) 32. Registrar's Signature

Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 004 34036 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician uran lichalle 25 2004 October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** altimore Baltimore University Medical System | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Year) | Under 1 Year | Under 24 Hrs. | 10 | Under 24 Hrs. | Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday 6. Sex **Funeral** 1 □ M 2 🖫 F 27 095-62-6987 Director 1977 New York Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-1 show other traumatic event, the Medical Examiner must be notified at 1x Yes 2 □ No Director New York Richmond Staten Island 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 329 Bedford Avenue 10306 or Items 23a IISA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Baltimore, Maryland 21215-0036 1 XYes 2 No Specify: Specify: White If Yes, Give Year or Dates: 3 Widowed 4 Divorced "natural". 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Legal Secretary Law Firm 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be if Department of Health and Mental t Important: If item 27 is marked ot any injury or other traumatic even once. Mental Jorge Duran 2 Sonia Medina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sonia Hutchinson Mother 329 Bedford Avenue; Staten Island, New York 10306 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State Rosehill Cemetery 10/30/2004 Linden, New Jersey ` 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Sterling Ashton Schwab Funeral Home, Inc. 21. Signature of Funeral Service Lice /36 Edmondson Avenue; Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Anemice **Physician** Aplastic month disease or condition /Medical resulting in death) Due to (or as a consequence of) Examiner raft Versus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed ytomegalourus that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Year Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Onknown P.O. 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, plort 1 Yes 2 No 3 Probably 4 Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 2□No 1 TYes To the Hospital or Attending Physician: the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 \ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number (10hr) 25,2004 s of person who completed cause of death (Item 23a) (Type, Print) 22 South Fre Bultimec Muyland treere Street 32. Registrar's Signature Registrar

	State of Maryland / Department of Health and M State Amend Items 28a-f per Dr., G836-10/27/04dhb 1. Decedent's Name (First, Middle, Last)	Reg. No	2004 34037
Physician /Medical	Melvin F. Dorman	Month Day	
Examiner	4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Northwest Hospital Randall. Standall.	1 MD 4c.	County of Death
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplece (State or Foreign Country), Bu hmit Min
Maryland -f ahow	Usual Residence of Decedent 10a. State		10d. Inside City Limits 1 ☐ Yes 2X No
with the Mar a or 28a-f at the nutified Director	10e. Street and Number 3849 Elmcroft Road 21133		ted States
be filed within 72 hours after death with the Maryland at Hygiene. Id other than "natural", or items 23a or 28a-f ahow event, the Mudical Exercit at mark to multified at Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never in U.S. Armed Forces? 1 Never Married 2 Never in U.S. Armed Forces? 1 Never Married 2 Never in U.S. Armed Forces? 1 Never Never in U.S. Armed Forces? 1 Never in U.S. If Yes, specify Cuban, Mexican, Puerto II Yes, Sive Year or Dates: Korean	ecity Yes or No-	14. Race - American Indian, Black, White, etc. Specify: White
ed within 72 hou ygiene. for then "nature t, the Mudical E	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 15a. Decedent's Usual Occupation (Give kind of work done during most of works) (ife. DO NOT use refired) 1 st Line Management	ing	ind of Business/Industry
should be filed with and Mental Hygiene. Marked other than matic event, the M	- Iso I Indiagement	(First, Middle, Maiden Perticone	T. & T Communicati
2 sh and Is m	19a. Informant's Name/Relationship (Type, Print) Spouse 19b. Mailing Address (Street and Number or Rural Market H. 1 C1 P. 2016 P.		
8° = 5	1 N Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place)	Date 20c. Lo	Maryland 21133 pocation - City or Town, Stele esville, Md. 21784
permit. Peg Department Important: any injury o	21. Signature Funeral Service Licensee 22. Name and Address of Facility Lor	ing Byers	Funeral Directors
Physician /Medical	23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac capacity, or heart failure. List only one cause on each line.	or respiratory arrest,	Approximate Interval Between Onset and Death
Examiner	Due to (or as a consequence of):		
icate be executed physician and the burial-transit clical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):		
= 0	d		
nat the death certif d by the attending letached for use a: Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of delivery Month Day Year
igne be d	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco u	use contribute to the cause of death?
		24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
/sici	25. Was case referred to medical examiner? 1 Yes 2 No	(Check only one)	6 □Other (Specify)
ding Phy h. After thi funeral o	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work?	28d. Describe how injur	y occurred
or Attan frer deat pirector: in by the	2 Activities 6 Could not be	28f. Location (Street and City or Town, State	all al landellet.
To the Hospital within 24 hours a within 24 hours a To the Funeral I completely filled	29a. Certifier (Check only declaration and/or investigation, in my opinion, death occurred at the time, date and place, a complete of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, a complete of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, a complete of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, a complete of the time, date and place, a complete of the time, date and place and place and place are complete of the time, date and place and place are complete of the time, date and the time, date and the time are complete of the time.	and due to the cause(s)	and manner as stated.
To the Hospital within 24 hours a To the Funeral C completely filled i	29b. Signature and title of certifier 29c. License number	29d. Dat	e signed (Month, Dav, Year)
3	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ramaia Gelzer Bell 8600 Chery Ad	Raide	10/21/0x Ustoun, MO21/33
State	Ramala Gelzer Bell 8600 Cherty 12 d 31. Date filed (Month, Day, Year) OCT 2 7 2004 Security Ramala Gelzer Bell 8600 Cherty 12 d	- Car separate	

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State of Maryland / Department of He	ealth and Mental Hygiene 🖺 🕦 📗

			Registrar Ce	rtificate of Death	Reg. No	
	Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Da	
	/Medic Examin	al	LILLIE M. DURANT 4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL	4b. City, Town, or Location of Death BALTIMORE CITY		3, 2004 5:42 P M
	Funeral Director		5. Social Security Number 220 24 9121 6. Sex 1 M 2 F 80 Yrs.	If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min.	B. Date of Birth $3/1/24$	9. Birthplace (State or Foreign Country) S. C.
	/land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits
	e Man	ctor	MD. n/a BA	LTIMORE		1 X Yes 2 □ No
	with the	Funeral Director	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Country?
	ns 23	erai	5009 PALMER 11. Marital Status 12. Was Decedent Ever in U.S. 13.	21215 Was Decedent of Hispanic Origin? (Spec	ifv Yes or No-	USA 14. Race - American Indian,
020	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "naturel", or Items 23a or 28e-f show event. Ite Modral Examination multiplied at	by	1 □ Never Married 2 □ Married 1 □ Yes 2♥ No	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto Ri	ican, etc.)	Black, White, etc. Specify: BLACK
ה	n 72 h "natu	letec	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working DO NOT use retired)	16b. F	Kind of Business/Industry
7 7	d withigher.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	KILL WORKER	A	CE CORP.
3	be filectal Hyg	BeC	17. Father's Name (First, Middle, Last)		First, Middle, Maidei	n Sumame)
<u>8</u>	2 should be filed withir and Mental Hygiene. Is marked other than eumatic event. It e M	ပ	PETER CARTER			HNSON
20	nd 2 st lith and 27 Is n			ng Address (Street and Number or Rural) 9 PALMER AVE . BA	-	or rown, State, Zip Code) . 21215
more,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 Is marked any injury or other treumatic evone.		20a. Method of Disposition 20b. Place of Disposition 20b. Place of Disposition State 20c. Place of Disposition Community, creation State 20c. Method of Disposition 20c. Place of Disposition Community Co		te 20c. L	ocation - City or Town, State
Dallimor	permit. Departm Importe any inju			ESTEP BROS. FUI 1300 EUTAW PL.		
			23a. Part1. Enter the disease, or complications that caused the death. Do not entshock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Arteriosclerotic Control Due to (or as a consequence of):	Cardiovascular Disc	asc	Onset and Death
	Examiner	<u>_</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
	nted I Insit	Examiner	Cause (Disease or injury			
Ď	exect en and rial-tra	Еха	resulting in death) Last C. Due to (or as a consequence of):			
00/00	tificate be executed by physicien and as the burial-transit	edical	d			
ŏ XO	± oue		IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
5.	the death by the atter ached for u	Physician/N		Ectopic pregnancy Other (specify)		Month Day Year
ecords, r	The law requires that the death cer ate has been signed by the attendin age 2 should be detached for use	by	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.		use contribute to the cause of death?
	has has	completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
N N	ysicien: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?	26. Place of Death (~	
5	Phys this al di	- To	1X Yes 2 □ No	7411	e 5 Residence	
SION	Attending F r death. ector: After by the funer	ation	1XXIatural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		ny occurred
DIVIS		Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, streaming building, etc. (Specify)	reet, factory, office 28	If. Location (Street ar City or Town, State	nd Number or Rural Route Number, e)
	To the Hospitel or within 24 hours afte To the Funeral Dir completely filled in	edicai (29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, deat XMedicel Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, an vestigation, in my opinion, death occurred	d due to the cause(s d at the time, date an	and manner as stated. d place, and due to the cause(s)
	To ti To ti comp	Ž	29b. Signature and title of entitier	29c. License number		ite signed (Month, Day, Year)
	\ .		1////	OCME	OC1	OBER 24, 2004
(V		30. Name and address of defson who completed cause of death (Item 23a) (Type,	111 Penn Street,	, Baltimor	re, Maryland 21201
	Sta		31. Date filed (Month Oly Year) 2004 32. Registrar's Signature	- /		
	Registr	ar	UC1272004 Deneva 19	souls!		

State of Maryland / Department of Health and Mental Hygiene, 34039 Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) October 22, 2004 **Physician** Doris Ann Fales 10:15 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8704 Wilson Avenue Parkville Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | September | September | Month, Day, Year | September | Month, Day, Year | September | S 9. Birthplace (State or Foreign Er 8, 1922 Mary and 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 2 🖾 F 215-18-2588 82 Director Usuel Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Example must be notified at Baltimore Mary land Parkville 1 ☐ Yes 2 X No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8704 Wilson Avenue 21234 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11. Marital Status within 72 hours after 1 Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8th permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: if item 27 is marked other It any injury or other traumatic event, ILL ODGS. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George E. Dorfler Bertha Ann Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary M. Steigen/Daughter 8704 Wilson Avenue Parkville Maryland 21234 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition other place) Gardens Of Faith 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/27/04 Baltimore Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Christina L. Hilton 22. Name and Address of Facility Leonard J. Ruck. Inc. 5305 Hartord Road Baltimore Maryland 21214 lton 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancer hna **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Liecaes or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 Yes 2 No 5 Other (specify) 4☐Pregnant at time of death the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? 2 1 No 2 □ No 1 Yes 1 Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ۵ 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Accident after death the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d, Date signed (Month, Dav. Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Samuel Durso, M.D. Johns Hopkins Bayview 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2004

State of Maryland / Department of Health and Mental Hygiens 1 - For State Registrar 34040 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Year Month **Physician** Ferrante Sebastian 5:00 AM october 22 2004 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center Baltimore City Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours **Ж** М 2 □ F 216-12-3190 Director July 10,1917 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iteme 23a or 28a-f ahrwany injury or other traumatic event, the Medical Execution 1000. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 TYes 2X XVo Dundalk Director Baltimore Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zio Code 21222 3439 Dunhaven Road United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify à Specify 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steel Industry Steel Worker 10 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frances Onarato Henry Ferrante 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20704 Daughter 3303 Castleleigh Road Beltsville, MD Marie Bena 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Most Holy Redeemer Cem. 10/25/2004 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. Confe 7922 Wise Ave. Dundalk, Maryland 21222 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** SCPSIS dai /Medical Due to (or as a consequence of) Examiner Mukemia myelogenous chronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the detached for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by I Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 1 Yes 2 No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No Certification: To 28a. Date of Injury (Month, Day Year) uneral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Iniun 1 Natural 5 Pending 1 Tyes 2 No investigation 2 Accident filled in by the Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES-000 October 22, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johns Hopicins Hospital Tower 110, Dactors Lounge, 600 North Wrife Street, Baltimore Maryland Lauren Averett 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State 2 7 2004 Registrar

State of Maryland / Department of Health and Mental Hygien 00 L 34041 - For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FUZIK **Physician** 160R 55 PM outober 23 /Medical 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** RANDALS TOWN HOSPITAL BALTIMORE NORTHWEST If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1X M 2 ☐ F 68 March 3, 216-61-2875 Director 1936 Ukraine Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene. Importent: if item 27 is marked other then "naturel", or items 23a are 200. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Directo Maryland Baltimore Reisterstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 32 Shropshire Court 21136 Completed by Funeral Russia 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced Russian 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Engineering Mechanical Engineer 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vladimir ပ Fuzik 01ga Lazarenko 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kateryna Fuzik 32 Shropshire Court Wife Reisterstown, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) All Saints Cemetery 10/25/04 Reisterstown, Maryland 11824 Reisterstown Road 21. Signature of Funeral Service Licensee. 22. Name and Address of Facility Eline Funeral Home Reisterstown, Maryland 21136 23a. Part1. Enrier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) ATHERO SCLEROTIL CARDIOVASCULAR DISEASE **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 785 autopsy performe 1 ☐ Yes 2 the Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 🗌 Yes 22 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 Death 2 Decident Certification: 28a. Date of Injury (Month, Day Year) 8b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funerel C Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title D43 erson who completed cause of death (Item 23a) (Type, Print) 30. Name and address of COTHKIN MD 5401 RAWSALLSTOWN DUD MICHAEL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 2004 34043 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Month Dav **Physician** OCTOBER 23 2004 10:30 A FRIEMAN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** PIKESVILLE BALTIMORE RUXTON PIKESVILLE NURSING HOME | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 12/15/1917 7. Age (In yrs. last birthday) 86 Yrs. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F MD Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 Is marked other then "neturel", or Items 23a or 28a-1 show any injury or other traumatic event, I'm Medical Event in errors be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No PIKESVILLE Completed by Funeral Director MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7 SUDBROOK LANE U.S.A. 21208 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No WHITE Baltimore, Maryland 21215-0036 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MANICURIST HEALTH CARE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be VARSUBSKY MINNIE STATTER ISAAC 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) EDWARD SWARTZ / SON -IN-LAW 3250 ANNULE DR. FINKSBURG, MD 21048 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State BETH EL MEMORIAL PARK 10/24/2004 RANDALLSTOWN, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS. INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Alzheimer's Disease Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury Due to (or as a consequence of) Examiner certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal dea 4 Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ² in by the funeral dir 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manney of Death Certification: 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00058676 October 23, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 200 Reisterstown MD 21136 25 Main Street Babitt M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar OCT 2 7 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier 1 34044 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 25,2004 4:05 AM Physician October Fabiszak Bertha /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Dundalk Genesis Eldercare-Heritage If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 217 – 26 – 9034 Days **Funeral** Months Jan5, 1913 Yrs. Maryland 91 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State ir than "naturel", or Items 23s or 28s-f show the Medical Examinar must be inclified at 1 ☐ Yes 2€No Essex Baltimore Md. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21221 Road 333 Savannah Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: Maryland 21215-0036 White þ 3 XWidowed 4 □ Divorced 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Completed (Give kind of work done during most of working life. DO NOT use retired) National Can Co. College (1-4or 5+) other than Elementary/Secondary (0-12) Worker Line 10th18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth any injury or other traumatic event ones. Josephine Jarosinski Joseph Mach 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 18 Anchor Way Drive Berlin, Maryland 21811 Fabiszak / Henry 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Baltimore, 20a. Method of Disposition

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart of Jesus Oct. 28,04 | Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilit Kaczorowski Funeral Home, PA 21. Signature of Funeral Sen ice Ligensee 1201 Dundalk Ave. Baltimore, Md. 21222 Talust 23a. Part 1. Enter the disease, or complications that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each Approximate Interval Between years Chronic Renal Failure Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): 25 years Essential Hypertension Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 9 Unknown Ö 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by 3 Probably 4 □Unknown 1 ☐ Yes 2 🗓 No Coronary Artery Disease Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No this certificate or Attending Physicien: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? funeral director, Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖁 No 2 ER/Outpatient 3 DOA 2 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: After 1 Natural 2 Accident 5 Pending 1 Yes 2 No investigation death. after death Director: / 28f. Location (Street and Number or Rural Route Number, City or Town, State) the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide within 24 hours a To the Funerel D XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 25, 2004 D 14160 4 30. Name and address of person who completed cause ol death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

M.D.

OCT 2 7 2004

32. Registrar's Signature

Harjit Singh,

31. Date filed (Month, Day, Year)

5410-A Ritchie Highway Baltimore, Maryland 21225

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- State of Maryland / Department of Health and Mental Hygien (1) 1 1-17-04 Fas Certificate of Death 34045 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Amy Marie Giorgakis **Physician** October 21, Chiveral 2004 1103 P ^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 875 Jay Dee Avenue Dundalk Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 ☐ M 2 🔀 F MAryland 220-02-4351 23 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show in than "natural", or items 23a or 28a-f show the Medical Examinar must be nutified at 1 Yes 2 No Dundalk Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 879 Jay Dee Ave. 21222 USA death 1 Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes **②【**No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 2 No Specify: Specify.White δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Orthopedic al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Physical Therpy Hand Rehab permit. Pages 1 and 2 should be filed v. Department of Health and Mental Hygie. Important: If item 27 is marked other 12 any injury or other traumatic event, IIIIs once. 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Minas Giorgakis Kelly Barker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Minas Giorgakis /father 3107 BirchBrook Lane Abington MD 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition MeadowridgeCemetery10/26/04 Baltimore MD ₩3 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ConnellyFuneralHomeofEssex 21. Signature of Funeral Service Licensee Baltimore MD 21221 300 MAce Ave 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List may one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Wound Physician Shotaun disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, physician Physiclan/Medical as the l attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Day 5 Other (specify) signed by the a d be detached for Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 □ No 24a. Was an has page 2 autopsy performed? 1 Xes 2 □ No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 NOther (Specify) 2 1 XYes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA At Scene this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 11:03PM 1 Natural 5 Pending 1 Yes 2 No 10/21/04 SUBJECT WAS Shot
281. Location/Street and Number or Rural Route Number,
City or Town, State) 2 Accident investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide in by t 4 Homicide 875 Jay Dec outside Baltimeremy 875 Jay Dee Ave Ave within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to time cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. October 22, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 m 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygien 2001 34046 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year GEE 3-45AM **Physician** 2004 ONONE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GENERAL HOSPIAN Hounge! COUNTY Carried 10 UMBIA If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 12/24/1920 9. Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1**XX**M 2□ F 83 229-16-8210 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State Pages 1 and 2 should be filed within 72 hours efter death with the Marylan nent of Health and Mental Hygiene.
ant: If Itam 27 Is marked other then "natural", or Items 23a or 28a-1 show ury or other traumatic event, the Medical Exertication and the notified at MXYes 2 □ No KINGS BROOKLYN NY Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 84 E. 91 STREET 11212 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1√2Yes 2 ☐ No If Yes, Give 11 Marital Status Black, White, etc. 1 ☐ Never Married XX Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: BLACK à 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) BAKER BAKERY 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ESTELL McCOULLOUGH WILLIAM GEE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 84 E. 91 STREET, BROOKLYN NY 11212 BESSIE GEE 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Department of Important: If It any injury or conce. Woodward funeral A 10/30/04 Brookly N 22. Name and Address of Facility FINK FUNERAL HOME, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signat A Fineral Service Livensee

KELLY CREGORY 426 CRAIN HIGHWAY S., GLEN BURNIE, MD 21061 FINK #M01148 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SMESTISE Immediate Sause (Final disease or condition resulting in death) LIEART **Physician** /Medical Due to (or as a consequence of) STENOSIS **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner HTPERTENSIN The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical attending pl IF FEMALE: 23c. if yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. by 1 Yes 2 No 3 Probably 4 Unknown leted Were autopsy findings available prior to completion of cause of death? 24a. Was an Compl performed 1 ☐ Yes 2 ☐ No 2 No 26. Place of Death Check onl one 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 2 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death al or Attanding P s after death. I Diractor: After Injury 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🔲 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Da 56948 (47STELAN KILENDING and address of person who completed cause of death (Item 23a) (Type, Print) CLOUDLEAP COURT, CONTRIA ND 21045 7548 TAMES IANTIMOA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygien 0 0 4 34047 1- State Registrar AMEND ITEM #10e PER FH G836 CONTINUE STATE OF Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 5pm October Dorothy Gray 13, 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Southern Maryland Hospitol Clinton Prince Georges County 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 3. Birthplace (State or Foreign (Month, Day, Year) | 3. Days | 4. Da 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 1 F Director 243-52-9412 Usual Residence of Decedent with the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a State 28a-f show the Medical Examiner must be notified at X□Yes 2□No Maryland Prince Georges Fort Washington Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'n 238 20744 United States America 8907 Loughran ROAD death Funeral 14. Race - American Indian, Black, White, etc. Itema 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2€ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) e filed within 72 hours after It Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black If Yes, Give Year or Dates: þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Compl College (1-4or 5+) Elementary/Secondary (0-12) Public Schools 12 Maintenance 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 should be f and Mental H is marked of Diley Walker Berry Gray ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum 8907 Loughran Road Fort Washington MD 20744 Agnes Johnson/Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Garden of Gethsemane 10/26/2004 Releigh Durham, N.C. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Fort Lincoln Funeral Home 3 Won צי 3401 Bladensburg Road Brentwood, Maryland 20722 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Cardiopulmonary Arrest disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or mijury Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): certificate be exe Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy I ive hirth 2 Fetal death Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the a Yes 2 No Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 XUnknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan autopsy performed? 1 Yes 2 XNo Division of Vital Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one. Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🙀 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred funeral Certification: After Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide ō Hospital 29a. Certifier 🛮 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of MD. D0061652 10-21-04 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) 9131 Piscataway Road #750 Clinton, Maryland 20735 Atul Katyal, M.D. 31. Date filed (Month, Day, Year) State OCT 2 7 2004 were & foote Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens 34048 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month ANN **GEASLEN** OCTOBER 5:50 A.M 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MARINER HEALTH OF FOREST HILL FOREST HILL HARFORD If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2 🗓 F Yrs Director 195-10-4005 FEUU217 VAMA Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "naturel", or items 23a or 28a-f show injury or other traumatic event, the Madical Examinal must be notified at 1 ☐ Yes 25€ No 000 WILD 03 Directo HARFOR DERBYERD 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code DRIVE U.S.A 1955 21040 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours efter l □Yes 25 No fYes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 □ Divorced BITTEW Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HERFERD LOUTY LIBROW BRARIA SYRS. permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anorxw 1ARY HOTVICH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33410 DRIVE PALOU AUDREY 6 EDWARDS HIJS MONUTOUR 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 46-700 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 1 ARYLAND 3004 LIKIESON 22. Name and Address of Facility Hevel - Galfire 21. Signature of Funeral Service Licensee EVAN FUNRAL TRANSPORT HILL SO KENDER OF THE POST OF TH DIPLYSH! 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** Kes /Medical **Examiner** ance Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day Month Year 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 1 🗌 Yes 2 🗌 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? /es 214 No After this certificate I 1 ☐ Yes 2 🗆 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 ANatural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation after death 2 Accident the 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

Division of Vital Records, P.O. Box 68760, within 24 hours a

> State Registrar

DR. ALBERT SUN 31. Date filed (Month, Day, Year) DCT 2 7 2004

29b. Signature and title of certified

(Check only one)

1716 HARFORD ROAD SUITE 105 32. Registrar's Signature

Om, u. w.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

-0018779

- FALLSTON, MD. 21047

29d. Date signed (Month, Day, Year)

(Ictober 23, 2004

State of Maryland / Department of Health and Mental Hygiene 34049 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) OCTOBER **Physician** 2004 7:40 A M **GERSHMAN** EVA /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE LUTHERVILLE BRIGHTWOOD NURSING HOME If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 01/03/1920 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1□M 2₩F 84 MD 220-05-5359 Yrs Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a State 10b. County 10c. City, Town or Location or 28a-f show if Health and Mental Hygiene. Item 27 is marked other than "natural", or Itams 23e or 28a-f show other traumatic avant, the Medical Examination and to publish a 1 Yes 2 No LUTHERVILLE MD BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 515 BRIGHTFIELD ROAD 21093 Funeral 12. Was Decedent Ever in U.S. Armed Forcies? 1 ☐ Yes 21 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE by 3 N Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) GROCERY STORE OWNER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BLUMENFELD **LAZARUS** BESSIE JULIUS ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 105 CHESAPEAKE AVENUE TOWSON, MD 21204 HOWARD CASSIN/NEPHEW 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State HEBREW YOUNG MENS 10/25/2004 WOODLAWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final DEVICTIT YR Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Lisease or injury Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, physicien use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) should be detached Division of Vital Records, P.O. the 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 100 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 Yes 2 No To the Hospitel or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Hursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To Director: After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manney of Death 1 Naturai Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide after within 24 hours a To tha Funeral C 1 (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Ve mo 2 ahi N 005 DCT 23 address of person who completed cause of death (Item 23a) (Type, Print) 7 305 TOWSON 21204 ws ALERN 036031 HARIS 31. Date filed (Month, Day, Year)
OCT 2 7 2004 32. Registrar's Signature State Registrar

		•	For State Registrar	State of Ma	C	ertificate of	Death		10 L L L L L L L L L L L L L L L L L L L	34050	
П	5		1. Decedent's Name (First, Middle, Las	st)				2. Date of Death	h Day Ye	3. Time of Death	
	Physicia /Medic		Michael Willia	am Gable				October	23, 2004		
	Examin		4a. Facility Name (If not institution, give	e street and number)			or Location of Death		4c. County of Death		
			Stella Maris			Timoniu		T		imore	
	Funeral		5. Social Security Number 6. S	ex 7. Age IXM 2□F	(In yrs. last birtho	Months Days	Hours Min.	8. Date of Birth (Month, Day,		Birthplace (State or Foreign Country)	
	Director		216-66-5319 Usual Residence of Decedent		49 "			Mar. 26,	1955	Maryland	
	land ow		10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits	
	Many -1 sh	to	Maryland Harford	3	Δhir	adon				1 ☐ Yes 2 ☐ X No	
	r 28a	Director	10e. Street and Number		4 10 41	10f. Zip Code		10	g. Citizen of What	Country?	
	th with	at D	7 Mitchell Driv	<i>r</i> e		2100)9		US	A	
	ems	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ever in U.S.	13. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-		merican Indian, /hite, etc.	
9500-61212	be filed within 72 hours after death with the Maryland ital Hygiene d other than "natural", or Items 23a or 28a-f show event, the Madical Examiner must be motified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 反 Divorced	1 XYes 2 ☐ N If Yes, Give Year or Dates:	lo	1□ Yes 2√ No			Specify:	White	
ž	2 hou	ted	15. Decedent's Ed	ducation	16a. De	ecedent's Usual Occup	pation		16b. Kind of Busine		
2	s filed within 72 h I Hygiene. other than "naturant, II e Mudic	Completed	(Specify only highest gra	College (1-4or 5	+)	ive kind of work done e. DO NOT use retire	d) auring most of work	aing			
	gient gient erth	Son	12			rdener			U.S. Gov	ernment	
2	d oth	Be (17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, N	faiden Sumame)		
<u>y</u> Z	should be nd Mental marked o	2	Edward David	Gable			Dorothy	<u> </u>	McLain		
Maryland	2 sh and and ls m		19a. Informant's Name/Relationship (ailing Address (Street					
	1 and 1ealth em 27 ther t		Larry Gable / Br	ouler		itchell Dr			20c. Location - City		
Baltimore,	ages or of the		1 ☑ Burial 2 ☐ Cremation 3 ☐			sposition (Name of crematory or other pla			·		
	it. Partmenturtant	. 1	*4 □ Donation 5 □ Other (Specifical Service Licer			rge's Epis			Perryman	, Maryland	
g	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic en		HAM OF	G	1	MCCOMAS FU	ineral'Hon	ne, P.A.	lon Mara	land 21009	
			23a Flart1. Enter the disease, or com	plications that caused	the death. Do not					Approximate	
	Discontinuo.		shock, or heart failure. List only Immediate Cause (Final							Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	a. LUNG CA	NCER a consequence of):						
	Examiner										
	~ -	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	a consequence of):						
	cuted	Examiner	Cause (Disease or injury that initiated events	c							
Ď,	rificate be executed ng physician and as the burial-transit		resulting in death) Last	Due to (or as a	a consequence of):						
68760,	cate b	Physiclan/Medical	•	d							
_	ding g	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy				Ood Date of	deli see	
ROX	death cert e attendin d for use	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		23d. Date of Month	Day Year	
o.	0 0	ysic	1 Yes 2 No	9☐ Unknown		oll out of (appeality)					
J.	law requires that the as been signed by th 2 should be detache	by Pt	Part II. Other significant conditions	contributing to death bu	ut not resulting in th	e underlying cause gr	ven in Part I.	23e. Did tob	acco use contribute	e to the cause of death?	
Records,	quires n sign ald be							1 □ Ye	s 2□No 3□	Probably 4 TUnknown	
၀	sw require s been sign	olete						24a. Was ar	24b. Were	autopsy findings available	
	Physician: The lavithis certificate has al director, page 2	Completed						autopsy perform	y prior ned? death YNo 1□Y	to completion of cause of	
Vital	an: rtifica	0	25. Was case referred to medical				26. Place of Deat	h (Check only one	A	00 20110	
>	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 🏋 No	Hospital: 1 ☐ Inpatie	nt 2 ER/Outpa	itient 3 DOA Ott	ner: 4 🗌 Nursing Ho	ome 5 🗆 Reside	nce 6 NOther (S	Specify) HOSPICE	
n of			27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Tim Year) Inju	e of 28c. Injur	ry at rk?	28d. Describe ho	w injury occurred		
20	Attanding ir death. ector: After by the fune	catl	2 Accident investigation			M 1	Yes 2 □No				
Division	2 9 5 6	Certification:	3 Suicide 6 Could not be determined			, street, factory, office		28f. Location (Str City or Town		Rural Route Number,	
_	ours a		29a. Certifier 1 V Certifying Ph	nysician: To the best oniner: On the basis of	of my knowledge d	eath occurred at the fi	me date and place	and due to the	usa/s) and mass	as stated	
	To the Hospital c within 24 hours af To the Funaral D completely filled in	Medical	(Check only one)	niner: On the basis of and manner sta	examination and/outed.	r investigation, in my o	opinion, death occur	red at the time, da	te and place, and	due to the cause(s)	
	fo the	Me	29b. Signature and title of certifier			29c. Licens	se number	29	d. Date signed (Me	onth, Day, Year)	
			1			Du	3725		1017	5/04	
	17gs		30. Name and address of person who	completed cause of de	eath (Item 23a) (Ty		- 103		.0/	4	
	10.		DR. TARIQ MAHMO		ULANEY VA	LLEY RD.	TIMONIUM,	MD 2109	3		
	Sta		31. Date filed (Month, Day, Year)	1	ar's Signature	Spaids					
	Registi	ar	OCT 2 7 2004	Defrer		popolis					

State of Maryland / Department of Health and Mental Hygiena For State Registramend ITEM #5 PER FH C837 11/16/64 Cate of Death 34051 2. Date of Death Decedent's Name (First, Middle, Last, Month Year **Physician** 2004 10:00A.M \$\psi\$ctober Elizabeth A. Holmes /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lorien Nursing Home Carroll Mt. Airy 5. Social Security Number 218-03-0524 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Month, Day, Year) 6/19/1919 1 M 2 F MD Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23e or 28a-f show other traumatic event, tre Modical Experiment and the notified at Ellicott City MD Howard 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 21043 U.S.A. 3004 North Ridge Rd. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Iter 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Bank Teller Banking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Raymond A. Holmes Julia G. Bell 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 16453 Old Frederick Rd. Mt. Airy, MD 21771 Barbara Turkel - Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 0 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. New Cathedral 10/25/2004 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Witzke Funeral Home of Catons-Teral Service Lice 21. Signatu ville 1630 Edmondson Ave. Catonsville, MD 21228 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CONGESTIVE HEART FAILVES Priysician 5hD STAGE resulting in death) /Medical Due to (or as a consequence of) Examiner CARDIOMYOPATHY CONGESTIVE 425 if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, use as the IF FEMALE: 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy jo Month Day Year 5 Other (specify) be detached of Vital Records, P.O. 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 2 No 1 Tes 1 Yes 2 ANO or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Certification: To 1 ☐ Yes 2 No 4 ✓ ursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Injury Division 1 Matural 5 Pending 1 ☐ Yes 2 No investigation after death.

Director: A 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by determined 4 Thomicide To the Hospital within 24 hours a To the Funeral Completely filled pelli Medical 29a. Certifier 1 Certifying Physician: The best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. asis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) are stated. 2 Medi xaminer: On an 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of co D-31912 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nD, 1564 of 055 mm 20 mg PILLE 21902 FREDERILY WENOCH 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2004

State of Maryland / Department of Health and Mental Hygiene 2004 34052 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** C Havlik 8142 Gregory 10 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Howard Howard County General Hospital Columbia Under 1 Year. If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min. 1**√**M 2□ F Months Hours 344-36-9537 59 Director June 19, 1945 Illinois Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow other traumatic event, the Medical Examinar must be notified at 1 XYes 2 No Director MD Ellicott City Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or items 23a or 3780 Plum Spring Lane 21042 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 □ No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes XXNo Specify: White Specify: If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Comptroller Manufacturing 12 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked Lillian Pitelka Edwin J. Havlik 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and important: If item 27 is n any injury or other traun 3780 Plum Spring Lane, Ellicott City, MD 21042 Janet Havlik/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 XCremation 3 Removal from State 10/25/2004 FALLS CHURCH, VA National Crematory * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilitySterling Ashton Schwab F.H., Inc. 21. Signature of Funeral Service Licenses 736 Edmondson Ave., Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final 1412 Enderd Testeridad trapell **Physician** 24/21. disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Frilore from Apportic Vano-ecclusive LivIT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner 8134454 The law requires that the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, BORY MARTIN TARREPORT Autolosius Physician/Medical HARGE FAITTUSY CALL LYMPKIMO IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Yes 2 No detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? λq Thrombolytopinia 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed Laterice Wastine 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No page 2 Awto Rrnal Failurt. Calhexia 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) nours after death.
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completely filled 📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and titte of certifier 29c. License number on 14. 030217 10-20-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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10. Name and Address of person who completed cause of death (Item 25 0 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Dianna 12:40am M Lee Hall October 0 26, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 600 Turf Farm Drive Sykesville Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country)
 PA 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □√F 217-50-2143 Yrs. Director 56 Sept 4, Usual Residence of Decedent filed within 72 hours after death with tha Maryland 10h County 10c. City, Town or Location 10a State 10d. Inside City Limits 27 is marked other then "natural", or items 23e or 28a-f show traumatic svent, the Madical Exam are must be notified at MD Carroll Sykesville 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 600 Turf Farm Drive 21784 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Agent Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any linjury or other traumatic event 9DCB. Be Phillip Staton Margaret Brauning 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Michael E. Hall (Spouse) 600 Turf Farm Drive Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State t X Burial 2 ☐ Cremation 3 ☐ Removal from State St. John's Lutheran Cem.10/29/04 Westminster, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee HATCHT FUNERAL HOME & CHAPEL, PA (Box 195) Buan 1. HUISCH Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Breast **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Attending Physicien: The law requires that the death certificate be axecuted that initiated events signad by the attending physician and d be detached for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Tes 21**X**No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home MHesidence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by that 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ō within 24 hours a To the Funerel C 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10/27/04 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Westminster, Md. 21157 Jaivatz 555 CRUTER m. D 31. Date filed (Month Car, 2ean) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiens 34054 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** october 20, 2004 0728 HARRINGTON RICHARD ORWELL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL PASADENA 7985 EAST RIVERSIDE DRIVE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month Day 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 6/2/1939 Year) Months 1**XX** 2□ F VERMONT 65 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State ed other than "natural", or items 23a or 28a-f show event, the Wedical Exemination to cultical at **PASADENA** MD ANNE ARUNDEL 1 Yes XXNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21122 USA 7985 EAST RIVERSIDE DRIVE death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Armes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or iten any injury or other traumatic event, the Wodisel Example once. Black, White, etc 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) DRIVER TAXT 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ALBERTA HACKETT JASPER HARRINGTON 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7985 EAST RIVERSIDE DR., PASADENA, MD 21122 OK JA HARRINGTON - WIFE 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XX urial 2 ☐ Cremation 3 ☐ Removal from State 10/22/04 GLEN BURNIE, MD GLEN HAVEN MEM PK * 4 □ Donation 5 □ Other (Specify) Licensee 21. Signature of Funera 22. Name and Address of Facility FINK FUNERAL HOME, PA GREGORY FINK #MO1148 426 CRAIN HIGHWAY S., GLEN BURNIE, MD 21061 KELLY Approximate Interval Between Onset and Death 23a. Part 1. Enter the disea shock, or heart failure or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause Immediate Cause (Final **Physician** disease or condition resulting in death) TEVIDSCLENO /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ pe 4 Onknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one examiner 1 Yes Hospital: Other: ome Residence 6 □Other (Specify)
28d. Tescribe how injury occurred 2∏No 1 Inpatient 2 ER/Outpatient 3□ DQA 4 Nursing Home funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: After 1 Natural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after deatl Diractor: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 | Homicide 24 hours a 29a. Certifier Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maritier as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. onel within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) use of death (Item 23a) (Type, Print) 30. Name and add ones 22. Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 2 7 2004 Registrar

Amend item 191st peroffinas 836d 10 e27 rt Herr of Health and Mental Hygier 10 14 34055 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician EDWARD JACKSON 7:00AM ROBERT 10 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MARIS Baltimore) Imonium If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 03.13.1039 **Funeral** 100M 2□ F 65 Yrs. 25.32.6265 MD Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 0-26-2004 @ 7:00 a.m item 27 is marked other then "natural", or itame 23a or 28e-f sho other treumatic event, it a Medical Exart for must be notified at 1 Yes 2 □ No MD BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 1038 DRIVE U.S.A. ELLICOTT 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 MYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Specify: BLACK 1 ☐ Yes 2 XNo Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene.
7 Is marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) VOCATIONAL REHAB COUNSCLOR STATE OF MARYLAND 12th grade Levears 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ROBERT ROOSEVELT BURKE HARRIET REBECCA JACKSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1038 Filicott Driveway Baltimore, Md. 21216 19a. Informant's Name/Relationship (Type, Print) DLUE E. JACKSON Health em 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ō <u>=</u> 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Importent: If any injury or once. 11.01.04 GARRISON FOREST * 4 ☐ Donation 5 ☐ Other (Specify) OWINGS MILLS, MD 22. Name and Address of Facility
VAUGHN (... GREENE FUNERAL SERVICES
SISI BAUTIMORE NAT'L PIKE, BAUTIMORE MD 21229 21. Signa re of Fune a Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Adenocarcinoma etas Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? s certificate has b lirector, page 2 s 2 No 2□ No 1 Yes 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence Sother (Specify) HOS PICE 212 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: After 5 Pending 1 Tyes 2 No death. investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours aft To the Funerel Di completely filled in Techtrying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Valley Rd, Timonium MD 21093 Mahmood. MD 230 Dulaney 31. Date filed (Mor 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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ORIGINAL

State of Maryland / Department of Health and Mental Hygiens 34057 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** TOINE 1058 PM October 212004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ho Bultimore Johns HOSPITA 8. Date of Birth (Month, Day, Year 2-12-1982 105 If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 XM 2 ☐ F Min Yrs. MARYLAND 22 214-02-6575 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits in then "neturel", or Items 23a or 28e-f show the Medical Examiner must be notified at 1 Yes 2 No Directo MD. N/A BALTIMORE 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code USA 2706 MURA ST. 21213 Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
sin: if item 27 Is marked other then "neturel", or Items 23, and it is the returnatic event, it as Netical Examination must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CLERK TELEMARKETING -11--0-17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ROSEMARY SMITH L.C. JETT ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROSEMARY JOHNSON (MOTHER) 2706 MURA ST. BALTIMORE, MARYLAND 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 3 □Removal from State 1 ☐ Burial 2 🔯 remation Department of Importent: If any injury or once. METRO CREMATORY 10-25-2004 BALTIMORE, MARYLAND ⁴ □ Donation Offer (Specify) D. HIBNER2. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signat of Fineral Service License TONATHAM 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Mas Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final SARCOMA Physician 6 MONTHS disease or condition resulting in death) /Medical **Examiner** IMMUNODEFICIENCY SYNDROME 6 MONTHS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner attending physicien and for use as the burial-transit To the Hospitel or Attending Physician: The law requires that lhe death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s performed: certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide within 24 hours a
To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cai 29a Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number OCTOBER 21, 2004 RES- 000 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NORTH WOLFE STREET, BALTIMORE, MARYLAND 21289 TTACHARYA BHA 600 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 27 2004 Registrar

State of Maryland / Department of Health and Mental Hygien 004 1 = For State Registrar 34058 Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** October 25, 2004 Dimitrios Kaliakoudas 10:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford 2620 Colpepper Road Abingdon If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. February 14, 1946 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 11XM 2□ F 218-64-4719 58 Yrs. Litonaro Greece Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar and Dings. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No Director MD. Harford Abingdon 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2620 Colpepper Road 21009 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2 X No Specify: by If Yes, Give Year or Dates: Specify: Greek 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Painter Construction 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Kaliakoudas Asimina Tsitzas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2620 Colpepper Road, Abingdon, MD. 21009 Sofia Kaliakoudas wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State October 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 28,2004 Dundlak, MD. ` 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundlak, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failule. It st only one cause on each the. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Glioblastoma disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed use as the burial-transit attending physicien and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2E] No 2 No 1 ☐ Yes 1 TYes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: Hospital: 1 Tyes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. To the 29b. Signature and tij le of 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) Alessandr 31. Date filed (Month, Day, Year) 32, Registrar's Signature State Registrar OCT 2 7 2004

State of Maryland / Department of Health and Mental Hygien 2004 34059 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vear 6:50 PM **Physician** OCTOBER PEARL KARWASH 24 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BACTIMORE CATON MANOR NURSING COME If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer, 10/27/1919 9. Birthplace (Stete or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 M 2XX Yrs. 84 PENNSYLVANIA 173-16-4932 Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at 1 XXes 2 □ No MD BALTIMORE CITY Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō USA 3330 WILKENS AVENUE 21229 238 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural, or Itan any injury or other traumetic event, it a Wedleal Example t Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: WHITE þ 3 XXidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **JANITRESS MAINTENANCE** 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ANASTASIA CHRUSZCZ PETER KALEMON 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5906 JOHNNY CAKE ROAD, BALTIMORE, MD 21207 DAVID KARSON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 XXuria) 2 Cremation XXRemoval from State 10/30/2004 ST. JAMES CEMETERY BESSEMER, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral S. Carlos 22. Name and Address of Facility FINK FUNERAL HOME, PA KELLY GREGORY FINE #MO1148 426 CRAIN HIGHWAY S., GLEN BURNIE, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) YEARS **Physician** ATHEROSCUEROTIC GARDIOVASCULAR /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Physiclan/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 □ Yes 2 No 9 □ Unknown Month 4□Pregnant at time of death 5 Other (specify) should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown DEMENTIN Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2★ No 24a. Was an page 2 autopsy performed? 1 Yes 2**/**2 No Vital or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3 DOA Certification: To 2 ER/Outpatient of 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funaral Director: A completely filled in by the fu 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Hospital 1 Yertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCTOBER 26 2004 DO05545 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EVTAW STREET, BACTIMORE AND 21201 GGAS AS 82 NAMA 32 Registrar's Signature 31. Date filed (Month, Day, Year) OCT 2 7 2004 Registrar

			1 - For Amend Registrar	Item 2	State o	f Maryla per Di	nd / Depa 7.,G8 27	artment of tificate	of Head	ith and M ath	ental Hy	gien e Reg. No.	004	34060
	Physici	20	1. Decedent's Name (Fi								2. Date of De Month	Day	Year	3. Time of Death
	/Medic		George Ric								10	19	2004	10:03 AM
)	Examir	er	4a. Facility Name (If not 106 Second			mber)		Glen E		cation of Death Le		Anı	ounty of Death ne Aruno	le1
	Funeral Director		5. Sociat Security Numb 036-20-9915	5 !	ex M 2□F	7. Age (In yi	s. last birthday) 73 Yrs.	If Under 1 Y Months D		Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 11/28/1930		9. Birthp Coun	lace (State or Foreign try) NY
	land W		Usual Residence of Dec 10a. State 10	b. County		10c.	City, Town or Lo	cation					1	0d. Inside City Limits
	Many I-f sh	ţ	MD Ar	nne Aru	nde1	G	len Bur	nie						1 ☐ Yes 21 No
	h the	Director	10e. Street and Number	r				10f. Zip Co	de			10g. Citize	en of What Cour	itry?
	23a (106 Second	Avenue	South			2106	1-		US		SA	
020	172 hours after death with the Maryland "natural", or Itama 23a or 28a-f show cored Essenings must be notified at	by Funeral	11. Marital Status 1 Never Married 3 Widowed 4		12. Was Dec Armed Fo 1X Yes If Yes, Gr Year or D	orces? 2 □ No 19 ve 10	53-	Was Decedent If Yes, specify 1 ☐ Yes 2☐	Cuban, N	anic Origin? (Spe Mexican, Puerto i Specify:	cify Yes or No Rican, etc.)		4. Race - Americ Black, White, Specify: Whit	etc.
21213-0030		Completed	(Specify of Elementary/Secondary	Decedent's Enough highest grains (0-12)	college (1-4or 5+)	(Give	DO NOT use r	one durii etired)	n ng most of workii	ng		of Business/Ind	
	73	e Co	17. Father's Name (Firs	st, Middle, Last	4		Phot	ographe		. Mother's Name	(First, Middle,			yeu
	□ = □ =	To Be	George Kou	_					l A	Agnes (u	nknown))		
Maryland	short ind N	-	19a. Informant's Name		•		19b. Maili	ng Address (St	reet and	Number or Rura	l Route Numb	er, City or T	Town, State, Zip	Code)
	and 2 lealth a m 27 ls		George Kou	cheravy	/ Son									
Ĕ		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or cemetery, crematory or other place) Clen Haven Mem. Park 10/22/2004 Clen Burnie											Burnie,	MD
Bail	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral H. 1 Second Ave. SW Glen Burnie, MD 2											
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the d shock, or heart ta Immediate Cause (Find disease or condition resulting in death) Sequentially list condition are sufficiently list conditions. Enter Underlying Cause (Disease or injust that initiated events resulting in death) Last	illure. List only al ions, oliate ng iny	interval Batween Onset and Death Due to (or as a consequence of): Acute Pneumonia b. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									
.O. Box 68/60,	The law requires that the death certificate be executed the sabeen signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/Medical E	tF FEMALE: 23b. Was decedent pre in the past 12 mor 1 □ Yes 2 □ No 9 □ Unknown	nths?	1 ☐ Live t 4 ☐ Pregr	If yes, outcome of pregnancy 1 □ Livre birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)						23	3d. Date of delive Month	ory Day Year
7	quires that the signed by ald be detacted	by	Part II. Other significar	nt conditions	contributing to d	leath but not i	esulting in the u	nderlying caus	e given ii	n Part I.	23e. Did t			ne cause of death?
I Records,		Completed									24a. Was autor period		prior to cor death?	psy findings available npletion of cause of
Vital	Physician: Th this certificate al director, pag	Be	25. Was case referred examiner?	to predical	Hospital:				Other	3. Place of Death	100000			
0	this al di	- To	1 Yes 2 No		28a. Date		ER/Outpatie		Injury at	4 Nursing Hor	ne 5 28d. Describe			()
Division	To the Hospital or Attanding I within 24 hours after death. To the Funeral Director; After completely filled in by the funer	Certification:	2 Accident	Pending investigation Could not be determined	n 28e. Place	oth, Day Year	Initury	М	Work?	2 □No		Street and		l Route Number,
۵	To the Hospital or Attandi within 24 hours after death To the Funeral Director: A completely filled in by the fa	edical Cer	29a. Certifier 1 (Check only 2 one)	Certifying Pl	miner: On the b	e best of my i	nowledge, deat	h occurred at t	he time, i	date and place, a	and due to the ed at the time,	cause(s) a date and p	nd manner as st	ated. the cause(s)
	To the vithin To the comple	Med	29b. Signature and title	e of certifier	sle	men	.M.	D. 296.1	cense nu		/		signed (Month,	•
			30. Name and address 31. Date filed (Month, I	and	Sce	se of death (t	10/4	7 90	V	Tyval	buit	nd.	6se	, 2004 61 Bennic 4 d 2106
	Sta Regist	ate rar	ncT2	7 2004	June	July 2	6	parks	/					

State of Maryland / Department of Health and Mental Hygie () 34061 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** KARLINSKY OCTOBER 5:55 P M 2004 **BERTHA** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** MONTGOMERY CASEY HOUSE ROCKVILLE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 11/03/1924 5. Social Security Number Birthplace (State or Foreign Country)
 MAINE 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🕅 F 218-20-0335 79 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits in than "natural", or Items 23a or 28a-1 show 1 Yes 2 No MD MONTGOMERY GAITHERSBURG Completed by Funeral Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 207 20877 U.S.A. 9 CHESTNUT STREET # Pages 1 and 2 should be filed within 72 hours after death neat of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23, and other traumatic event, its Medical Examine must 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 10 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **ACCOUNTANT** ACCOUNTING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **ADAMS** TOMCHIN RAPHAEL IDA 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11803 OLD GATE PLACE ROCKVILLE, MD 20852 ANITA LANN / NIECE 20b. Place of Disposition (Name of 20a. Mathod of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or otl once. 10/24/2004 BALTIMORE, MD BNAI ISRAEL CONG. * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 nt). Enter the disease, or ock, or heart failure. List omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CEREBRAL CARCINOMATOSIS Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exercises) Due to (or as a consequence of): Examiner to the Hospital or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PAST HISTORY OF LUNG CANCER 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 20 No 2□ No 1 Yes 1 Yes 25. Was case referred to medical examiner? v Be 26. Place of Death (Check only one) HUSPICE Other: 4 Nursing Home 5 Residence 6 Other (Specify examiner: X 1 ☐ Yes 2 ☐ No. Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) After thi 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Z Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title who completed cause of death (Item 23a) (Type, Print) Harri 31. Date filed (Month, Day, Year)
OCT 2 7 2004 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygien 34062 Certificate of Death Req. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 17:47 PM onald 04 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Maryland Med Balto Md University If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Min Days 12XM 2□ F 219-50-4943 57 June 19,1947 Director Maryland Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location show or than "natural", or Items 23a or 28a-f shover than "natural", or Items for notified at 1 ☐ Yes 2X No Director Maryland Perry Hall Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21236 United States 7 White Wood Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 ☐ No If Yes, Give 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 Specify: Specify. þ White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Plumber Union 486 12 Years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Cecelia Rolnick Henry Los ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7 White Wood Court Perry Hall, Maryland 21236 / Wife Mrs. Linda Los 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition - to - to 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 10/30/2004 Towson, Maryland permit. Pag Department Important: I any injury o □ Donation 5 □ Other (Specify) 21. Sigr ure of Funeral Service Licensie Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Approximate Interval Between Onset and Death 23a. Part1 Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final orunan **Physician** disease or condition resulting in death) /Medical nce of) Examiner Sequentially list conditions, lay Learn to the cause. Enter Underlying Cause (Disease or injury Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day Month Year in the past 12 months? 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 00 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s this certificate 1 Yes or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 2 ER/Outpatient 3 DOA 2 Yes 2 No 1 npatient 5 Residence 6 Other (Specify) Il Director: After this 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Manner of Death 27 D te of Injury (Month, Day Certification: 1 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral 6 ro the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal Chalo horaer 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Mou AU-4174 435 A15313 J, and address of person who completed cause of death (Item 23a) (Type, Print) - Kez Baltman MD ABRISHAMUTIAN 31. Date filed 32. Registrar's Signature State 2004 Registrar

State of Maryland / Department of Health and Mental Hygien 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Myrtle H. Leland 10:50 PM 2004 25 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BAITIMORE Reseate
If Under 1 Year If Under 24 Hrs. FRANKliN HospilA. SQUARE 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1□M 2QF 220-34-5618 90 April15,1914 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits the Maryland 10a. State 10b. County show rel', or items 23a or 28e-f shov Examiner must be notified at 1 ☐ Yes 2 X No MD Baltimore Essex Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21221 USA 222 Oberle Ave. Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Yes **2√∆**No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Baltimore, Maryland 21215-0036 SpecifyWhite Completed by 3€ Widowed 4 Divorced "naturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other traumatic event, I've Wedical and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) own home Homemaker 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Helen Dilley John Sann 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) CaroleeMae Yannacci/daughter 222 Oberle Ave. Baltimore MD itam 27 I Date 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition ō **=** 1 Burial 2 Cremation 3 Removal from State More LandMemorial 10/29/04 Baltimore MD permit. Page Department of Important: If any injury or once. 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ConnellyFuneralHomeofEssex 21. Signature of Funeral Service Licensee 300 Mace Ave. Baltimore MD 21221 23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Approximate Interval Between Onset and Death ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Immediate Cause (Final Embolism Physician UlMOVARY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the derived Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. I 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No certificate Hospital or Attanding Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 XNo Certification: To this 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation after death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours an Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D17347 10-25-04 30. Name and address of person who domp SCHARE DR. BAITIMORE Md. 21237 9000 FRANKLi DR STEVEN 32. Registrar's Signature 31. Date filed (Month, Day, Year) OCT 2 7 2004 Registrar

	_	1	For State Registrar	State	of Mary	land / Depa	artment <i>tificate</i>	of H	ealth an Death		Reg.		34064
Phys	iciar	_	. Decedent's Name (First, Middle, Las	t)		LEE				M	ate of Death Ionth	Day Year	
/Me	dica	1	MARGARET a. Facility Name (If not institution, give	street and n	umbar)	4-1-		Town, or	Location of D		ober 2	25 2004 905 4c. County of Death 1	
Exan	nine		Johns Hopkins Ca					etin					NA
Funer	_		. Social Security Number 6. S			yrs. last birthday) Yrs.	If Under Months		If Under 24	Min. (A	ate of Birth Month, Day, Ye PT. 26	ear) (irthplace (State or Foreign Country)
		-	Jsuel Residence of Decedent		10	c. City, Town of Lo	ocation						10d. Inside City Limits
arylan show			10a. State 10b. County	(ODE	10								1 XYes 2 □ No
the M		ب د	MD BALTI	MORE		TURNER S	10f. Zip				10g	. Citizen of What (Country?
3a or	Č		423 MAIN STREET					2122	2			USA	
death me 2		Laurel	11. Marital Status	12. Was De Armed I	cedent Ever	r in U.S. 13.	Was Deced	ent of Hi	spanic Origin n, Mexican, P	? (Specify)	Yes or No-	14. Rece - An Black, Wh	nerican Indian, hite, etc.
ire, Mial yial I. Z. I. Z. I. Z. C. C. C. C. S. S. Should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It marked outher than "natural", or Iteme 23e or 28e-f show other traumatic event, the Medical Examinational Description at	1	2	1 Never Married 2 Married 3 Widowed 4 Divorced		2 DMNo Bive		1□Yes 2		Specify:				BLACK
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within than the New		E	Elementary/Secondary (0-12)	College	(1-4or 5+)	<i>///</i> 6.		ESTI				HOME	
filed with Hygiene. other ther	1		17. Father's Name (First, Middle, Last,				DOIL			s Name (Firs	st, Middle, Ma	iden Sumame)	
should be nd Mental marked o	1	10 De	FRANK LEE						JOSE	EPHINE	BLACK	WELL	
and 2 should beath and Ment			19a. Informant's Name/Relationship (CLARENCE N. BELL/									City or Town, State N, MD 21	
ages 1 and 3 out of Health t: If item 27 y or other tra			20a. Method of Disposition 1 X Burial 2 Cremation 3 C 4 Donation 5 Other (Specia		1	20b. Place of Dispo cemetery, cre MT . HERM	matory`or o	ther plac		Date 0/30/2		c. Location - City (EIDSVILL)	
permit. Pages Department of Importent: If ite	ouce.		21. Signature of Funeral Service Licer		lon	2	2. Name an	d Addres	s of Facility	JAME	S A. M		SONS F.H., IN
, så,	第 :	+	23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications tha	t caused the	death. Do not en	ter the mod	e of dyin	g, such as ca	ardiac or res	piratory arrest	,	Approximate Interval Between
Physicia	an		Immediate Cause (Final disease or condition	4.4	anarv	Tract	Tin	lecti	on.				Onset and Death
/Medic	al .		resulting in death)	d.	11000	onsequence of):	l)					
Examin		_	Sequentially list conditions, if any, leading to immediate	b	o (or as a c	onsequence of):							
rted		Examiner	Cause (Disease or injury			, ,							
6U, be executed ician and burial-transit		Exa	that initiated events resulting in death) Last	Due	o (or as a c	onsequence of):							
Ite be e		cal	,	d									
J.O. BOX 68/60, It the death certificate be executed by the attending physician and rached for use as the burial-transit	3	Physician/Med	IF FEMALE:	020 16.000								004 D-44 46	to live and
BOX atth cel attendir	3	lan	23b. Was decedent pregnant in the past 12 months?			Fetal death 3	⊒Ectopic p					23d. Date of d Month	Day Year
the deched	2	iysic	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	9 Un									
- E D 6		by Pt	Part II. Dther significant conditions	contributing to	death but n	not resulting in the	underlying o	ause giv	en in Part I.		23e. Did toba	cco use contribute	to the cause of death?
Cords w requires been sig			stroke								1 🗆 Yes	2 □ No 3 □	Probably 4 Unknown
Hecords, he law requires t e has been signe	2 2	Completed	Hypertension	1, di	abete	es					24a. Was an autopsy	prior 1	autopsy findings available to completion of cause of
	Day.	Com	Chronic rena	(insu	fficie	ncy					performe 1 ☐ Yes 2)2	ed? death No 1 ☐ Y	
F Vital F ysician: Th is certificate	960	Be (25. Was case referred to medical examiner?	Hospital				Oth			neck onlone		
- S = 0	5	2	1 Yes 2 No 27. Manner of Death	1		2 ER/Outpatie		JA	4 pa ivuis	22.71		ce 6 Other (S	pecify)
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Division or Attending after death. Director: After	em ka u	Certification:	3 Suicide 6 Could not determined	28e. Pla	ace of Injury ilding, etc. (- At home, farm, s (Specify)	treet, factor	y, office			Location (Stre City or Town,		Rural Route Number,
Div To the Hospitel or A within 24 hours after To the Funeral Direct	completely filled in by	edical C	29a. Certifier 1X Certifying P	miner: On the	the best of re basis of ex anner state	my knowledge, dea camination and/or i	ith occurred nvestigation	at the tir	ne, date and pinion, death	place, and o occurred a	due to the cau t the time, dat	se(s) and manner e and place, and c	as stated. due to the cause(s)
To the To the	duo	Me	29b. Signature and title of cartifier	nn	/				e number			d. Date signed (Mo	
			Michel flex	Cant	P	MO	4	03.	73/6			10-25	-2007
V		1	30. Name and address of person who	Re //	ause of deal	th (Item 23a) (Type	, Print)	05	Hunker	hs B	as the	Circle	Buldinge mo
700	Sta	te	31. Date filed (Month, Day, Year)	32	2. Registrar's			0	1		1000		
Re	gistr		OCT 2 7 2	:004	Bens	ve p	14	out.					

DHMH 17 Rev 1/2001

State of Manyland / Department of Health and Mental Hygiene O O I

		Registrar 1. Decedent's Name (First, Middle, Last)		rtificate of L	Death	2. Date of Death	g. No.	3. Time of Death 2005
Physici /Medi	al -	Chester Na. Facility Name (If not institution, give street and num	M. Lawerenc		Location of Death	Oc	t 24, 2004 Year	141
Examir	ier	U.M.M. Shock T			Baltim		N/	
Funeral Director		217-18-5685 1⊠M 2□F	. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Jul 11,	Year) 9. Birt 1920 9. Birt	holace (State or Foreign unitry) Viaryland
Maryland I-f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland N/A	10c. City, Town or Lo		ltimore			10d. Inside City Limits 1 Yes 2 No
h with the 23a or 28a st be noti	Funeral Director	10e. Street and Number 1701 Eutaw Street Apt # 616		10f. Zip Code	21217	10	og. Citizen of What Co U.S.	A.
ite; Mal ylail of ILI 3-0000 s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decer Armed For 1 Yes, Given Year or Date of Date	2 ☑ No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (Spanic Origin? (Spanic Origin) (Spanic Origin	ecity Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
Malylatin Z. I.Z. 13-0030 nd 2 should be filed within 72 hours aft th and Mental Hygiene. 27 is marked other than "natural" or traumatic event, the Modical Exert.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-	(Give	dent's Usual Occup a kind of work done DO NOT use retired La	during most of work	ing	16b. Kind of Business/ Constr	
dillu ZIZI d be filed within antal Hygiene. (ed other than b	Be	12 17. Father's Name (First, Middle, Last) Joseph Lawrence	l l		18. Mother's Name		Maiden Sumame) e Cooper	_
i, Mally all IN and 2 should be a salth and Mental n 27 is marked o	To	19a. Informant's Name/Relationship (Type, Print) Katherine Lawerence Wife	19b. Maili 4 4	ing Address <i>(Street</i> 402 LaPlata A	and Number or Rura ve. Baltimore,	Maryland 2	, City or Town, State, 2 1211	Zip Code)
SALLIMOTE, IN Permit. Pages 1 and 2 Department of Health Important: if I tem 27 i any injury or other tre page.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from 5 1 ☐ Donation 5 ☐ Other (Specify)		osition (Name of ematory or other place National Mem	(e)	10/29/04	20c. Location - City or Laurel, N	
Dalfillion permit. Pages Department of Important: If I any injury or o		21. Signature of Fugeral Service Licensee	1	22. Name and Addre Estep B 1300 Et	rothers Funer utaw Place Ba	al Home P.A altimore, MD	A. 21217	
fificate be executed (giphysician and as the burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Inflected or as a consequence of): or as a consequence of): or as a consequence of):	Intra O		shot Wo	und	Interval Between Onset and Death
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RECORDS, P.O. BOX 66/00, The law requires that the death certificate be executed the has been signed by the attending physician and agge 2 should be detached for use as the buriat-transit.	Physician/Me	230. Was decedent pregnant 1 Live b	ant at time of death 5	☐Ectopic pregnanc	<i>y</i>		23d. Date of de Month	livery Day Year
uires that signed by lid be deta	þ	Part II. Other significent conditions contributing to de	eath but not resulting in the	underlying cause giv	ven in Part I.		bacco use contribute t es 2⊠No 3□P	o the cause of death? robably 4 Dunknowi
Vital Records, sician: The law requires! certificate has been significaten, page 2 should be	Completed					24a. Was a autops perform	sy prior to death?	utopsy findings available completion of cause of
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DIVISION To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director:	edical Ce	29a. Certifier (Check only check on the check only check on the check	hest of my knowledge, dea	ath occurred at the ti	me, date and place, opinion, death occur	and due to the c	ause(s) and manner a	s stated.
To the within 2 To the comple	Med	29b. Signature and title of pertifier		29c. Licen	se number 176435		29d. Date signed (Mon 10 /26/20	th, Day, Year)
6		30. Name and addless of person who completed cause PAYID 5. LAMITIE D.		e, Print)			re, Maryla	nd 21201
S Regis	tate		Indicted the Signature	& Lon			_	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens 34066 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10:00 A.M 2009 /Medical 4a. Facility Name (If not institution, give street and number) Town, of Location of Death County of Death Examiner If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** -14-4166 1 M 2□F Min Months Days Hours Director Usual Residence of Decedent death with the Maryland 10c. City, Jown of Location 10d. Inside City Limits d other than "natural, or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 Yes ANO Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No WW 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, 2 No W. W. Z filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Specify: Whi þ 3 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry le marked other than Elementary/Secondary (0-12) College, (1-4or 5+) Martin Marrietta ar IA Eather's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be Lanahan orenc eeman (Son 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Pages 1 and 2 Department of Health a Important: If item 27 le _anahan 20b. Place of Disposition (Name of cametery, crematory) or other 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licen -e 23a. Part. Intervine displace, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock or heart failure. List only orgecause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE MYDCARD, II any in Parkville, MD. 21234 Approximate Interval Between Onset and Death Pnysician /Medical Examiner HYPERE 112 1D omi A Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner CHYPERTONS ION The law requires that the death certificate be executed Due to (or as a consequence of) attending physician Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Dav 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9☐ Unknown 9 Unknown signed by Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ CHRONIC ROVER WSUFFICIETOY 3 Probably 4 □Unknown 1 Yes 2 No Completed peen s ANOMIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: Certification: To 5 Unesidence 6 ☐ Other (Specify) 4 Nursing Home 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No

Division of Vital Records, P.O. Box 68760. Hospital or Attending Physician: within 24 hours after death, To the Funeral Director: After this funeral in by the

> 04 Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year, OCT 2-7 2004

2 Accident

3 ☐ Suicide

29a. Certifier

883

Medical

4 Homicide

(Check only one)

29b. Signature and title of certifier

investigation

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rd.

6 Could not be

BALTIMOR 32. Registrar's Signature

1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

725010

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

M		-	For State	Sta	te of M	laryland		ertment of H		d Mental Hyg	211	04	31,067
			Registrer 1. Decedent's Name (First, Mid	dle, Last)				incate of i	Journ	2. Date of Dea	h		3. Time of Death
	Physicia /Medic		JOAN	NE		Ε.		LEVY		OCTOBE	R 23, 20	904	5:58 P M
	Examin		4a. Facility Name (If not institut. 5480 WISCONS)	-	nd number)		4b. City, Town, or		eath	4c. County		
	Europal		5. Social Security Number	6. Sex	7. A	ge (In yrs. lasi	t birthday)	CHEVY (JHASE If Under 24 H	Irs. 8. Date of Birth	MONTO	place (State or Foreign	
	Funeral Director		220-90-8253	1□M 2	XF	41	Yrs.	Months Days	Hours M	in. NOV . 25	1962	Coui	CT CT
	and W	-	Usual Residence of Decedent 10a. State 10b. Coun	ly		10c. City, T	own or Lo	cation					10d. Inside City Limits
	r 28a-f ehow	tor	MD	MONTGO	MERY		CHEV	Y CHASE					1 ☐ Yes 2 No
	with the Maryland a or 28a-1 ehow	Director	10e. Street and Number					10f. Zip Code		1	0g. Citizen of V	What Cou	•
	death w		5480 WISCONSI			t Ever in U.S.	12.1		20815	/Coopfu Vac or No	14 Pag	o Amori	USA can Indian,
10	fter de r Item	Funeral	11. Marital Status 1 X Never Married 2 Marrie	arried Am	ed Forces	?				(Specify Yes or No- lerto Rican, etc.)		ck, White,	, etc.
936	72 hours after natural', or ite	þ	3 Widowed 4 Divorc	. If Y	es, Give ' ar or Dates:	•		1 □ Yes 2 🕅 No	Specify:		Specify	/: 	WHITE
15-0	s within 72 hours jiene. r than "natural", tha Medical Ex	Completed	15. Deced (Specify only high	ent's Education lest grade comp	leted)	1	I6a. Deced (Give	ient's Usual Occup kind of work done o DO NOT use retired	ation du <i>ring</i> most of v	working	16b. Kind of Bu	usiness/In	idustry
212	s within jiene. r than	omp	Elementary/Secondary (0-12	5+ Col	lege (1-4or	5+)		ICIAN	,		MEDICI	NE	
bu	e file al Hyg othe	BeC	17. Father's Name (First, Middle	, ,						lame (First, Middle,	Maiden Surnan	10)	
Maryland 21215-0036	2 should be filed within n and Mental Hygiene. r is marked other than "raumatic event, the Me.	P	ROBERT		SAAC	—	10b M-111-	LEVY	ELLEN		C'h T	C4-1	FEIS
	es 1 and 2 should b of Health and Ment: I item 27 is marked r other traumatic e		19a. Informant's Name/Relatio					-		RANDOLPH,			Code)
altimore,	ages 1 ar nt of Hea : if item or othe		20a. Method of Disposition	2 Minamana	I from Chate	000	e of Dispo	sition (Name of natory or other place	PARK	Date	20c. Location -	City or To	own, State
i ii	Page Iment tant: if		1 ☐ Burial 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other	(Specify)	THOM State	9	I ABR	AHAM MEM	ORIAL 1	0/27/2004			
Ball	permit. Page Department Important: if any injury o		21. Signal of unera Service	e ligense						SOL LEVINS N ROAD - P			
	ja ja		23a. Part V. Enter the disease, shock, or heart failure. L	or complications	that cause	ed the death.							Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	a	Mu	HIPLE							Onset and Death
	/Medical Examiner		resulting in death)		ue to (or a	s a consequer							
1		er	Sequentially list conditions, if any, leading to immediate	b	ue to (or a	s a consequer	nce of):					-	
/	ocuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1 c									
8760,	be executed sician and burial-transit	al Ex	resulting in death) cast		ue to (or a	s a consequer	ice of):						
687	cate phys	edical		d									
Box	eath certific attending p	an/M	IF FEMALE: 23b. Was decedent pregnant			e of pregnancy 2 Fetal de		Ectopic pregnancy				te of delive	
	The law requires that the death certifiate has been signed by the attending page 2 should be detached for use as	by Physician/M	in the past 12 months? 1 □/Yes 2 □ No 9(☑ Unknown]Pregnant a]Unknown	at time of deat		Other (specify)			Mo	nth	Day Year
P.O.	that the	y Ph	Part II. Other significant cond	itions contributir	ng to death	but not resulting	ng in the u	nderlying cause give	en in Part I.	23e. Did to	pacco use cont	ribute to ti	the cause of death?
Records,	w requires been sign should be									1 □ Y	s 275 No	3 Prot	bably 4 Unknown
eco	e law re has be	Completed								24a. Was a autops	y	Were auto	opsy findings available ompletion of cause of
al B	cate har,										2□ No	leath?	2 No
Vital	Attending Physician: Thr r death. sctor: After this certificate by the funeral director, pag	To Be	25. Was case referred to medi examiner? **TOXYes 2 \(\) No	Hospita	l: 1 🗆 Inpat	ient 2 TEB	l/Outnatien	t 3 DOA Oth	05	Death <i>(Check only or</i> g Home 5 Reside		ar (Specif	ty) SCENE
Jo C	ding Phy h. After this funeral o		27. Manner of Death 1 Natural 5 Pen		Date of Inj	jury 28	Bb. Time of		y at	28d. Describe ho			" SCENE
Division	tendir leath. tor: Af the fu	catic		stigation	0/23/0	04 5	1461	2 M 1 🗆	Yes 2 No	SUBJECT J			teight
Div.		Certification;	4 Homicide dete	mined 28e	building, e	etc. (Specify)	e, tarm, str	eet, factory, office		City or Town	n, State)	S COCIO	al Route Number, Consin AVY,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: / completely filled in by the fi		29a. Certifier 1 ☐ Certification Check only 2 ☑ Medic	ying Physicien:	To the bes	t of my knowle	edge, death	occurred at the tin	ne, date and pla	ace, and due to the c	ause(s) and ma	nner as s	stated.
	To the H within 24 To the Fi complete	Medical	one) 21	an	d manner s	stated.	T and/or in	29c. Licens		ocurred at the time, d			
	To Cor		29b. Signature and title of cert	21/	1 /	1/	_		M E	2	9d. Date signe OCTOBE		
	5		30. Name and address of pers	who complete	d cause of	death (Item 2)	За) (Туре,	Print)			•		3 04-04
_	8		JACK N	(ithe)	M.D.			111 F	enn Sti	reet, Balt	more,	Mary	land 21201
	Sta Registi		31. Date filed (Month, Day, Ye GCT 2 7		2.	trar's Signatur معمر	4	Sparks	,				
	·		00101	F004	land 1	1	· ·	ground					

State of Maryland / Department of Health and Mental Hygien 0 0 4 34068 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** OCTOBER LEDERKREMER 2004 5:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CATERED LIVING OF PIKESVILLE BALTIMORE N/A 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 OLAND **Funeral** 1**∑**M 2□F 94 219-30-7899 Yrs. Director Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show the Medical Examiner must be notified at 1 Yes 2 □ No Be Completed by Funeral Director MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 7218 PARK HEIGHTS AVENUE 21208 U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No 3 X Widowed 4 □ Divorced 'naturel' 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) SALES RETAIL .. Pages 1 and 2 should be filed v tment of Health and Mental Hygie tant: if item 27 is marked other t jury or other traumatic avant, II. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ARYFH **IFIB** LEDERKREMER SZAINA KORENBLITT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SARAH SCHABES / FRIEND 6309 PIMLICO RD. BALTIMORE, MD 21209 20b. Place of Disposition (Name of 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State permit. Page Department of Important: if any injury or once. TIFERETH ISRAEL 10/24/2004 ROSEDALE, MD `4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Euneral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate the therval Between Onse and Death tmmediate Cause (Final Atheroscieratic Cavaliouus cular **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): nding physician ause as the burial P.O. Box 68760 To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetat dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetat death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year 4☐Pregnant at time of death Month Day 5 Cher (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. sign. Dementia, renul insufficing Diabetes mellitis, 1 🗌 Yes 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2000No 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 Alo Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Vursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) After thi 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 ZNatural 2 Accident 5 Pending death. investigation 1 Yes 2 No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 045432 October 23, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ZICUZESVOADE DV. #400 OWING MILLS MD ZILL7 Tamary S. Schel, ULD 31. Date filed (Month, Day, Year) 32. Registrar's Signature OCT 2 7 2004 oaks Registrar

			For State Registrar	State of Mi	Ce	ertificate of	Death		g. No.	4 34069
	Physicia		Decedent's Name (First, Middle, Last John Edward	Mills				2. Date of Death Month October	Day 25, 200	3. Time of Death 9:45 p. M
	/Medio Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death	000000	4c. County of	
	Funeral Director		5. Social Security Number 6. S 219-36-1704		e (In yrs. last birthda) 64 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 10	, 1940 9	Birthplace (State or Foreign Gountry) Maryland
	Maryland -f show lied at	tor	Usual Residence of Decedent 10a. State 10b. County Maryland N/A		10c. City, Town or Baltimo					10d. Inside City Limits 1 N Yes 2 □ No
	th with the 23a or 28s	al Direc	10e. Street and Number 4818 Hamilton Av	enue Apt	1D	10f. Zip Code	21214	10	og. Citizen of What United	States
920	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, I're Madical Exerciter must be notified at an ance.	by Funeral Director	11. Marital Status 1 Never Married	12. Was Decedent Armed Forces? 1 Pes 2 X If Yes, Give Year or Dates:	Ever in U.S. 13	3. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2X No	dispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indian, White, etc. White
1215-0	vithin 72 ho ne. han "natur e Modicel	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		(Giv	edent's Usual Occup ve kind of work done DO NOT use retire	pation during most of worki d)	ing	6b. Kind of Busin	
Maryland 21215-0036	id be filed v ental Hygie ked other t Ic event, III	To Be Co	12 yrs. 17. Father's Name (First, Middle, Last, Edward Mills			DI I VCI	18. Mother's Name Betty	Fleisc	faiden Sumame)	
Mary	ind 2 shou alth and M 27 is mar er traumat	-	19a. Informant's Name/Relationship (Турө, Print) s / Wife		iling Address <i>(Street</i> 8 Hamilto			City or Town, Sta ltimore,	
Baltimore,	Pages 1 ament of He ant: If Item ury or othe		20a. Method of Disposition A Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	y)	Most Holy	position (Name of rematory or other pla / Redeemer C	em. Oct.	28,2004		ore, Maryland
Balt	permit. Depertr Import. any inj		21. Signature of Euneral Service Lice	Michael E	E. Canapp	22. Name and Address Leonard	Ss of Facility J. Ruck, J		305 Harf altimore	
	Prysician /Medical Examiner		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each li	the death. Do not ene.		ng, such as cardiac c			Approximate Interval Between Onset and Death
68760,	tificate be executed ig physician and as the burial-transit	sal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter the corrying Cause (Disease or injury that initiated avents resulting in death) Last	с.	a consequence of): a consequence of):					
.O. Box 68	death cer e attendir d for use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date of Month	
S, D	8 5 0	by	Part II. Other significant conditions of	contributing to death b	out not resulting in the	underlying cause gi	ven in Part I.	23e. Did tob		ute to the cause of death? Probably 4 Unknown
Record	The law ete has t page 2 s	Completed	<u></u>					24a. Was ar autops perform 1 Yes 2	y pric ned? dea	re autopsy findings available or to completion of cause of ath?
Division of Vital	inding Physicien: ath. r: After this certific ne funeral director,	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Magner of Death 1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be		ury 28b. Time ay Year) Injur	of 28c. Inju		me 5 Reside 28d. Describe ho	nce 6 V Other w injury occurred	(Specify) Hospice
Divi	To the Hospitel or Attend within 24 hours after death To tha Funerel Director: completely filled in by the		4 Homicide determined	building, e	jury - At home, farm, tc. (Specify)		- data and place	City or Town	, State)	or Rural Route Number,
	thin 24 ho tha Fune mpletely f	Medical		nysician: To the best miner: On the basis of and manner s	of examination and/or		opinion, death occur	red at the time, da	ate and place, and	
	To with		Milraile	completed cause of	death (Item 23a) (Tur	D58	333			a 26 2004
	5		31. Date filed (Month, Day, Year)	ues mo	rar's Signature	J. Charles	St Balt	smore h	10 212	04
	St Regist	ate rar	OCT 2 7 200		so b	Soone	/			

State of Maryland / Department of Health and Mental Hygien 2004

34069

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiens Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** October 19,2004 MARIE MOBLEY 12:30P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Laurel Regional Hospital Laurel If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 TAF November 25, 1923 579-52-8062 Yrs. Virginia Director 80 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 Nos 2 No Director Prince George's MD Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20707 USA 14200 Laurel Park Drive 238 death Funeral Items 2 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 DYes 2 No If Yes, Give Year or Dates: ō 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: Black 3 Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Own Home Housewife unknown permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 le markad othany injury or othar traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Willie J. Mobley, Jr./Son 2208 Brightseat Road, Landover, MD 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Riverble Park Cremetory 10 10/26/2004 Riverdale, MD 21. Sunature of Fineral Service Icensee once Cedar Hill Funeral Home, Inc. 4111 Pennsylvania Ave. Suitland, MD 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Aspiration Preumonia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): burial-Box 68760 physician Physician/Medical esn IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Congestive Heart Failure 3 Probably 4 Unknown 1 Yes 2 XNo ector, page 2 should Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 21 No 1 Yes 2 **X**No or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide To the Hospital within 24 hours a To the Funeral D 📈 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and e of certifier 29c. License number 10/21/04 D54488 WD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bennett So, M.D. 8317 Chenry Lane, Laurel, MD 20707

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygieng 0 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** October Edward A. Mooney, Jr. 20 06:30 AM 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Hanes nealthcare If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 1 M 2 □ F Yrs. Director 212-05-2281 94 August 17,1910 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28e-f show other treumatic event, the Medical Examinar must be notified at Director 1 ☐ Yes 2 No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 846 Stanford Road 21229 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No þ Specify. 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "ns any injury or other treumatic event, the Medit once. Elementary/Secondary (0-12) College (1-4or 5+) Policeman Law Enforcement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edward A. Mooney Mary Gillan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward A. Mooney, III (Son) 106 Nicodemus Road Reisterstown, Maryland 21136 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State ⁴ □ Donation 5 □ Other (Specify) New Cathedral Cemetery10-23-04 Baltimore, Maryland 22. Name and Address of Facility
Witzke Funeral Home of Catonsville, Inc.
1630 Edmondson Ave. Catonsville, Maryland 21228 21. Signature of Funeral Service Lic 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or as a consequence of): 2 hrs disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sunsequence of): Examiner physician and the burial-transit Due to (or as a consequence of): Physician/Medical as the b IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: director 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Direct 1. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P17006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Caton avenue Bultimore Mary tea 1th care 31. Date filed (Month, Day, Year) 32 Registrar's Signature OCT 2 7 2004 Registrar Grant

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2004 34072 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** October 0 22 2004 1:16 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Baltimore Greater Baltimore Medical Towson If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1□ M 2 F 213-28-8395 73 Director MAKEN 26,193 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itams 23a or 28a-1 show other traumatic evant. The Madical Examinar must be notified at 1 Yes 2 No SALTIMORE Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. ☐Yes : 2 No 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: by Specify: BLACK 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7. h and Mental Hygiene. 7 Is marked other than "n: College (1-4or 5+) Elementary/Secondary (0-12) 45515TAN 1 9TH VURSING STELLA! 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be NIL500 VIOLa SNOWDEN 2584 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health as Important: If item 27 Is any injury or other trau <u>once</u>. CROXTON/Clarafter 4431 51. CHARGES BACTO, 118BORAH md. 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore. 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 29/04 CEMETERY 101 4 □ Donation 5 □ Other (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility CROMINGTE -CHAYS 2431 E. OLIVER 57. . 21213 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Metosta **Physician** Ovarian ueq. /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 5 Other (specify) <u>о</u>. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy performe 2□ No 2 No 1 Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nation 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 2 this 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I

completely filled 29a Certifier 📐 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Marie 020907 m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar 569

31. Date filed (Month, Day, Year)

Charles

N

St

32. Registrar's Signature

ORIGINA

Sparker

State of Maryland / Department of Health and Mental Hygien 004 1 - For State Registrar Certificate of Death Req. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 25 **Physician** MCFADDE ANGELIA 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL SECOURS BATIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 214-64-6202 Director 48 North Carolina Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show it e Wedical Examiner must be notified at 1 X Yes 2 □ No MD Director NA BAltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1503 W. Fayette St. Apt B 21223 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: à 3 Widowed 4 Divorced **Black** Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene.

Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: if Item 27 Is marked any injury or other traumatic events. Joseph J. McFadden Maggie O. Jones ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1503 W. Fayette Street Apt B Balto, MD 21223 Chernika A. Watson/Daughter 20a. Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State * 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park 10-27-04 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home 638 N. Gilmor St. Balto, MD 21217 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA Priysician /Medical Due to (or as a consequence of): Examiner A105 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician by Physician/Medical as the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? EAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပ 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours To the Funeral 29a. Certifier 1 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2720272 no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Strongs mAS MILLEN 710 31. Date filed (Month, Day, Yeer) State

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Registrar

ORIGINAL

OCT 2 7 2004

State of Maryland / Department of Health and Mental Hygie 20 1 1 - For State Registre Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Sylvester /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number (In yrs. last birthday) **Funeral** Months Days Hours Director 12-29-1942 Jamaica Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State rel', or Items 23a or 28e-f show Examirer must be notified at 1X Yes 2 □ No Director MD NA Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21217 1000 Gilmor Street USA Completed by Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel" ~ "--- any injury or other treumetic even. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. ☐Yes 2X No Yes. Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Stock 12 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Mavis Mowatt John Mowatt ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4114 Hanwell Road Randallstown, MD 21133 Erika D. Moot / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory 10-26-04 4 ☐ Donation 5 ☐ Other (Specify) Catonsville, MD Juneral Sep 22. Name and Address of Facility Wylie Funeral Home 638 N. Gilmor St. Balto,MD 21217 hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Part1. Enter the disease, or complications shock, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Dei zwel Sequentially list conditions, 1 any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last Due to or as a consequence of Physician/Medical Examiner VIB burial-transit The law requires that the death certificate be exec-Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year for in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Š 1 🗌 Yes 2 12 No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of oause of death? 24a. Was an autopsy 2 No 1 Yes 214 No To the Hospitel or Attending Physicien: 25. Was case referred to dical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Limpatient Certification: To 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Zwitural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide within 24 hours a To the Funerel [11 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number pleted cause of death (Item 23a) (Type, Print) West Battimore Street Battimore MD 21223 gistrar's Signature 31. Date filed (Month, Day, Year) State 7 2004 Registrar

State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Viv<u>ian Miles</u> October 2004 11:36A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Frederick Hospital Frederick 8. Date of Birth (Month, Day, Year) Oct. 24, 1 If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) **Funeral** 1□M 2₩F Director 215-32-8343 76 1928 MD Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 21 No Director MD Carroll Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23e or 4101 Baltimore National Pike 21771 death 1 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. hours after 14 Never Married 2 Married Saltimore, Maryland 21215-0036 "naturel', or 1 ☐ Yes 2 No Specify: Specify: **B1ACK** 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "na eny injury or other traumatic svent, the Media 2006. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor of Housekeeping Health Care 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Ernest Sylvester Miles Katie Simms Dorsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Roderick F. Miles (Son) 3215 Milford Ave., Baltimore, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Bushy Park Cemetery 10/28/2004 | Cooksville, MD 21. Signature of Funeral Service Licensee HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Man Sykesville, MD 21784 (410)-795-1400 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsus Priysician /Medical Due to (or as a consequence of): **Examiner** Gram POSITIVE (OCC-RMIG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed physician and the burial-transit Hypiensum Due to (or as a consequence of): Box 68760, Physiclan/Medical CITE for use as ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. Q□ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 11 GTCan 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No +(MOLCO autopsy mea? 2\Q\No 1 🗆 Yes Hospitel or Attending Physicien: tor: After this certific the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification; To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 \ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and use to the dause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 ho To the Fune completely fi (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10-24-04 40061117 parier a X auce 400 W. JEVENIM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fronessed DO A-Doniels Frederick MD 31. Date filed (Month, Day, Year) QCT 2 7 32. Registrar's Signature State 7 2004 Registra

State of Maryland / Department of Health and Mental Hygiene 004 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** HATE (8)0(V) 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner DEMPSTR 3501 APT. S HERFORL If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 0 M 2 □ F Yrs Director 317 34 3836 LARYL Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28e-f show other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No 1, 100 Mars BALTIPORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a STIR LOURT 21234 Α, Completed by Funeral 3501 HF 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 250 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify: WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 127RS OFFICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 GEORI-Spidtens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 323 19a. Informant's Name/Relationship (Type, Print) If item 27 6.1 PSTER LOURT MARIA 3501 AECT MARKENTE 20b. Place of Disposition (Name of cemetery crematory or other place) Date 20a. Method of Disposition 20c. Location - City or T wn, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ö permit. Page Department of Important: If any injury or once. 1964 F300 * 4 □ Donation 5 □ Other (Specify) 3004 4167250 21. Sona ure of uneral service ticensee 22. Name and Address of Facility = (CRIZZ HEHE ROGO [KAYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 205 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner o the Hospitel or Attending Physicien: The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): Box 68760 IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day ρ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown 9 Unknown Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ pe 2 No 3 ☐ Probabty 4 ☐ Unknown 1 🗌 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 autopsy 25 No 1 Yes funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ⚠ Residence 6 ☐ Other (Specify) 1 Inpatient 2 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 28d. Describe how injury occurred After Natural Natural 5 Pending investigation after death. 1 Tyes 2 No 2 Accident 6 ☐ Could not be 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 - Homicide within 24 hours a To the Funeral C Certifying Physician: To he best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On his basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check or one) hanner stated. 29d. Date signed (Month, Day, Year) 665R 25 2001 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 2 7 2004 Registrar

Michael Minossi Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-06911 For Unpend Item 23a, 27, 28a f per me 6839 11 16 04 tas Registrar Certificate of Death dl 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Vaar **Physician** Minossi Michael 7:59 A Ihomas October 25, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Rosedale 10 Guinevere Court 8. Date of Birth (Month, Day, Yea 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months Days Hours 10 M 2□F 25 218-94-1635 20-ANIN Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Show item 27 is marked other than "natural", or items 23a or 28e-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No TARKVI 11e Director DALTIMOR 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21234 SA 2806 12. Was Deceder by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. ont: If item 27 is marked other then "natural", or iter 1 Never Married 2 Married 2 NO 1 Yes 1 ☐ Yes 2 No Specify: White. Baltimore, Maryland 21215-0036 Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Detes: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) YLOVER 10 ina 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be M Inomas Minossi Krause Hona 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ridge Rd permit. Pages 1 and 2. Department of Health as Importent: if item 27 is any injury or other traconce. 28CloA Kings Farkville, MD 21234 Inomas & Anna Minoss: - Parents 20b. Place of Disposition (Name of cemetery, crematery or other place) 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State Date 20c. Location - City or Town, State 10/29/04 5 ☐ Other (Specify) • 4 □ Donation UNGRAL CHAPEL-22. Name and Address of Facility BACTIMOLE, MD 21234 21. Signature of Funeral Service Licent CHAPEL, 8800 HARFORD PD EVAND FUNERAL round 23a. Part1. Enter the disease, or confplications t shock, or heart failure. List only one cause s that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Narcotic(Heroin)Intoxication Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine anding physician and use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No for 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s has autopsy performed: teath? Yes 2□ No certificate 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 DOther (Specify) SCENE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 2 No 1 XYes this After thi funeral (28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury Certification: Found: Found: 7:51 1 Natural 5 Pending investigation 1 □ Yes 2 🛣 No Unknown 2 Accident 6X Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospitel or Attending Physicien: death. Director: • Funeral

4 Homicide

29a. Certifier

Medical

State Registrar

determined

Found:Residence

Rosedale, Baltimore County,

(Check only one) 29b. Signature an

29c. License number

29d. Date signed (Month, Day, Year)

October 26, 2004 **OCME**

son who completed cabe 30. Name and address of per of death (Item 23a) (Type, Print)

Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

within 2

0

ORIGINAL

28f. Location (Street and Number or Rural Route Number, City or Town, State) 10 Guinevere Ct

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State of Maryland / Department of Health and Mental Hygien 200 L 34078 For State Registrar Certificate of Death 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 615 AM **Physician** LEE NICHOLS -MA MPIA 10 21 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE If Under 1 Year | If Under 24 Hrs. CALLID 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Dey, Year) 9. Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days Hours Min 1 M 2 F 215-34-459 CAILISLE 1938 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County you wan Hadih and Menial Hygiene.
If item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, it a Medical Examinar must be notified at 1 Yes 2 No ALTIMORE Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number LOT 21212 HIAN CAS Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 21215-0036 1 Yes 25 No Specify: WHITE 3 Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) USTOMER TERVICE EIAIL 12 18. Mother's Name (First, Middle, Maiden Sumame) Maryland 17. Father's Name (First, Middle, Last) Be Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10111 DAW/ DANGHER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages OCTOBER 25 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State +ARKVILLE permit. Page Department important: If any injury or once. · 4 Donayon 5 AQther (Specify) ENTEM SMEW FACKWOOD CEMETER! 2004 HARFORD 21. Signatory of Funeral S Ligensee 22. Name and Address of Facility PARKYILLE, MO EVANS CHAFEL OF MEMORIES Approximate Interval Between Onset and Death Part I. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Mir th **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical the attending pl 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 menths?
1 Yes 2 No 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ Yes 2 🗆 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autopsy performed 1 ☐ Yes 20 No 1 TYes certific 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home Residence 6 Other (Specify) 2 No ٩ 1 Yes 2 ER/Outpatient 3 DOA Pis 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After t Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours after de e Funaral Directo letely filled in by to 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature 30929 completed cause of death (Item 23a) (Type, Print) Charles ST 3 Registrar's Sign State Registrar

			1- State of Marylar State of Marylar	nd / Department of Health and M Certificate of Death	lental Hygier	2004	34079
	Physicia	an	Decedent's Name (First, Middle, Last)			Day Year	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	OCT	4c. County of Deat	
ı	LXamii	CI.	4/100 Barminston Loa	d Baltimore		NA	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. 151–30)–8102 78	Asst birthday) Yrs. If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birth	hplace (State or Foreign untry) S, C.
	yland now		Usual Residence of Decedent 10a. State 10b. County 10c. Ci	ty, Town or Location			10d. Inside City Limits
	e Mar Ba-f st	ctor	MD. NA	Batimore			1 Mayes 2 □ No
	with the	Dire	4100 Parrington Road	10f. Zip Code	10g. (Citizen of What Co	untry?
	death	Funeral Director	11. Marital Status 12. Was Decedent Ever in Under Armed Forces?	.S. 13. Was Decedent of Hispanic Origin? (Spell of Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame Black, White	
36	within 72 hours after death with the Maryland ene. than "natural", or Items 23s or 28s-f show the Medical Examinar must be notified at	by Fu	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 No If Yes, Give Year or Dattes:	1 ☐ Yes 2 No Specify:	1 (104.1)	Specify: D	INOV
21215-0036	72 hou natura lical E	ted !	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work)	16b.	Kind of Business/	Industry
121	within and than "I	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)	ng		0110
	e filed Il Hygie other	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maid	en Sumame)	NIH
aryland	should be to and Mentall marked o umatic eve	To E	George Allen Nelson	Henrie	Ha Bri	yant	
\geq	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinat must be notified at once.	-	Parkara Nelsyw	19b. Mailing Address (Street and Number or Rura	Route Number, City	For Town, State, 2	12/\ 7
ore,	es 1 a of Hea if item or othe		20a. Method of Disposition 1 Description 2 Cremation 3 Removal from State	Place of Disposition (Name of cemetery, crematory or other place)	Date 20c.	Location - City or	Town, State
Baltimore,	it. Pages rtment of I rtant: If it njury or o		*4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Licensee	Urison Forest 11-1- 22. Name and Address of Facility Vol	04 OW		ills, MD
Ba	permit. Departr Imports any inju		7 Qualm C. J.	- 8728 Liberty Rd. K		own, MC	rual Service
	94.		23a. Part1. Enter the clisease, or complications that caused the deal shock, or heart failure. List only one cause on each line.		or respiratory arrest,	200111212	Approximate Interval Between
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death) a Dehydra				Onset and Death 5-10d
ľ	Examiner		Due to (or as a consec	Altaneimers			104
F	sit s	iner	Sequentially list conditions, and any, leading to anniectate cause. Enter Underlying Cause (Disease or injury	uencu at:			
,	execution and ial-tran	Examiner	that initiated events c. Due to (or as a consec	(uence of):			
8760,	icate be executed physician and s the burial-transit	dicai	d				
9	E O	0)	IF FEMALE: 23c. If yes, outcome of pregnant	ancy		23d. Date of deli	verv
). Box	0 0 0	by Physician/M	in the past 12 months? 1 Yes 2 No			Month	Day Year
P. 0.	The law requires that the site has been signed by the bage 2 should be detache	Phy	9 Unknown Part II. Other significant conditions contributing to death but not res	sulting in the underlying cause given in Part I.	23e. Did tobacco	o use contribute to	the cause of death?
rds,	w requires tha been signed should be det		Hypertension		1 🗆 Yes	2 €No 3 □ Pro	obably 4 Dünknown
Record	law requast been 3 2 should	Completed	Seizure disorder		24a. Was an autopsy	prior to c	topsy findings available ompletion of cause of
al H		e Con	25. Was case referred to medical		performed?		2 No
f Vital	Physician: The lav this certificate has ral director, page 2	To Be	examiner?	26. Place of Death Death Other: 4 Nursing Hor	me 5 Residence	6 ☐ Other (Spec	ify)
Division of			27. Manner of Death 1 Avatural 5 Pending (Month, Day Year)	28b. Time of 28c. Injury at Work?	28d. Describe how in		
/isic	l or Attend after death Director: ,	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At h	M 1 ☐ Yes 2 ☐ No ome, farm, street, factory, office	28f. Location (Street		ral Route Number,
á	ital or A irs after ral Direc led in by	Cert	4 Homicide building, etc. (Special	y) 	City or Town, Sta	ife)	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medicai	29a. Certifier 1 (▼Certifying Physician: To the best of my kno (Check only one) 1 (Check	owledge, death occurred at the time, date and place, a ation and/or investigation, in my opinion, death occurre	and due to the cause ed at the time, date a	(s) and manner as ind place, and due	stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	29c. License number	29d. E	Date signed (Month	, Day, Year)
			Shella Chalkers 10	D25663		127/04	
	1		30. Name and address of person who completed cause of death (Iter	n 23a) (Type, Print) = Balhmyre Md 2121	10		
	Sta		31. Date filed (Month, Day, Year) OCT 2 7 2004 32. Registrat's Signation	ature			
	Registr	ar	UU 1 2 1 2004 Page	De sports			

State of Maryland / Department of Health and Mental Hygien O U 4

Certificate of Death 34080 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year NELSEN Physician 458 M estelle 2004 DCL /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** Ellicott City Health & Rehab. Howard Ellicott Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1 □ M 2 🗙 F 90 Director 356-40-1868 MD. Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10b County 10a, State f show the Medical Examinar must be notified at 1 XYes 2 ☐ No Director MD. N/A Baltimore or 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21210 USA 105 W. 39th Street Apt 207 Items 23a death Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after. Hygiene. other than "naturel", or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White þ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygien. Important: If item 27 is marked other the any injury or other treumatic event. 12 years Own Home **HOusewife** 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Addie Estelle Brooks Walter Olin Collins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2825 Lodge Farm Road, Apt 116, Edgemere, MD. 21219 Walter O. Collins nephew 20b. Place of Disposition (Name of October 27, 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ▼Burial 2 □ Cremation 3 □ Removal from State

4 □ Donation 5 □ Other (Specify) Lakeview Memorial Grd 2004 Sykesville, MD. Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final a Imonar Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, ed by the attending physician detached for use as the buria certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Year in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day 5 Other (specify) 4☐Pregnant at time of death is been signed by the 2 should be detache 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed certificate has been rector, page 2 shoult 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 Yes o the Hospital or Attending Physicien: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de To the Funerel Directo completely filled in by th 4 Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier och he 26 2004 Clarella 30641 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ver NECK ROOD 201-109 Japapalm 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State Registrar

OCT 2 7 2004 DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

Pamela E- Scuthall

ORIGINAL

32. Regetrar's Signature

111 Penn Street, Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygie 10 1 34082 State Registra AMEND ITEM #5,17&18 PER FH G858 THE GROUP OF THE REGISTRAL BELL OF THE RE 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Yeer October 2006 2: 10 AM Olejnik Iwan /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Good Samaritan Hospital Baltimore n/a 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral ™** 2□F Days Hours Yrs. Director Apr 30, 1916 215-30-9003 Ukraine Usual Residence of Decedent 10a State 10d. Inside City Limits 10h Counts 10c. City. Town or Location Show men xx se marked other then "naturel", or items 23e or 28e4 show other traumatic event, It a Medical Examiner qual be notified at Md. n/a Baltimore 1 ☑ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 635 South Montford Avenue 21224 Ukraine Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 8th <u>General Laborer</u> A & P Bakerv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Maryland Be is marked o Olejnik KATHERINE PUTLO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peter Olejnik (son) 209 Emerson Avenue Glen Burnie, Md 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) St. Michael Ukr. Oct. 29 Baltimore, Md. 22. Name and Address of Facilitaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee kuly 1201 Dundalk Ave. Baltimore, Md 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ongestive heart Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner myocardial infarction Sequentially list conditions, if any, leading to inniediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last death certificate be executed use as the burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 D Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ unchiec tasis 1 Yes 2 No 3 Probably 4 2Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2□ No 1 ☐ Yes 2 No 1 Tyes funeral director Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Management 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 5 Pending death. M 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital or within 24 hours a To the Funaral C 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD RESOOO October 26,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Waida Hannoush, MD Good Sameritan Hospital 5601 Lock Roven Blvd. Baltimore, MD 21239 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

VOID

CERTIFICATE

2004-34083

SEE

CERTIFICATE #

2004-35130

State of Maryland / Department of Health and Mental Hygien 004

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			State Registrar		Cert	ificate of I	Death		Reg. No	.004	3400	4
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	xamin		4a. Facility Name (If not institution, give s	-		4b. City, Town, or Baltima	Location of Dea		40	County of Dea	th	
	neral ector			7. Age (In yrs. last b	irthday)_ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		rth av, Year 1, 1	9. Bit	thplace (State or Fo cuntry) Pnn.	oreign
and	A		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tox	wn or Loc	ation					10d. Inside City L	imits
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th with th	23a or 2 uat be n	al Dire	6131 Dunroming Ro	oad		10f. Zip Code 2123	9	1. 10		tizen of What C U.S.A.	ountry?	
3-UU30 72 hours after death with the Maryland	r than "natural", or items 23a or 28e-f show the Medical Examinat must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		as Decedent of H Yes, specify Cuba	ispanic Origin? (in, Mexican, Pue Specify:	Specify Yes or Note Rican, etc.)	0-	14. Race - Am Black, Whi Specify: W		
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90 %	at ta		Elementary/Secondary (0-12)			ner	-0.14			stauran	L	
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Mar nd 2 sh	17 to		19a. Informant's Name/Relationship (Ty. Mrs. Evie Williams	- Daughter	115	Address (Street a				or Town, State, , MD 21		
W - T	a =		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	ery, cremi	ition <i>(Name of</i> atory or other place emetery	10/	Date 29/04		ocation - City or altimore		
Departin	Importent: If ite any injury or of once.		21. Signature of Funeral Service License	a troop of		Name and Address		Baltimor Inc. 5				
FEE	16		23a. Part1. Enter the disease, or complishook, or heart failure. List only or	cations that caus at the death. Do	not ente	r the mode of dyin	g, such as cardia	c or respiratory a	arrest,		Approximate Interval Betwee	en
	sician edical		Immediate Cause (Final disease or condition resulting in death)	ון איני מכח וכן		lens					Onset and Dea	tn
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cuted	nd transit	Examiner	cause. Enter Underlying Cause (Disease or figury that initiated events resulting in death) Last	·								
Certificate be executed	iding physician and ise as the burial-transit		Tosailing in oddiny East	Due to (or as a consequence	e of):							
X 68	ing ph e as th	/Medical	IF FEMALE:						I			
	ned by the attend detached for us	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnancy Other (specify)				23d. Date of de Month	livery Day Year	r
ecords, P.O. Broad law requires that the death	been signed by should be deta	by	Part II. Other significant conditions con	ntributing to death but not resulting	in the und	derlying cause give	en in Part I.		tobacco Yes 2		the cause of death	
Vital Hecords, sicien: The law requires t	certificate has beer irector, page 2 shou	Completed						24a. Was auto perf	ormed?	prior to death?	utopsy findings ava- completion of causi	ilable e of
E = 1	rtificat tor, p	0	25. Was case referred to medical				26. Place of De	1 ☐ Yes ath (Check only	2 ☑ No one)	1 Yes	2 □ No	
_ %	o ≥	To B	examiner? 1 ☐ Yes 2 ☑ No	lospital: 1 Inpatient 2 ER/C		3□ DOA Oth	er: 4 🗆 Nursing	Home 5□Res	idence	6 ☐Other (Spe	cify)	
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DIVISION Tel or Attending s after death.	ei Directo ed in by ti	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, stre	et, factory, office		28f. Location City or To			ural Route Number,	5
Dry Fo the Hospitei or within 24 hours afte	To the Funerei Director: completely filled in by the	edical (29a. Certifier 1 Certifying Physical Check only one) 2 Medical Exami	sician: To the best of my knowledger: On the basis of examination a and manner stated.	ge, death and/or inve	occurred at the tine estigation, in my o	ne, date and place pinion, death occ	e, and due to the urred at the time	cause(s , date an	and manner a d place, and du	s stated. e to the cause(s)	
To tf withir	To the	M	29b. Signature and title of certifier	}_		29c. Licens	e number			te signed (Mon	n, Day, Year)	
	3		30. Name and address of person who co		(Type, P	rint)	2 Hivar	cm r	uu	2.5		
	Sta Regist		31. Date filed (Month, Day, Year) OCT 2 7 2004	22. Registrar's Signature	1	books						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** PRATT 2004 8-26A M JAMES 007 23 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GENESIS MANOR CARE NURSING CENTER TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day, Year) 9-16-1919 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral ¼**☐ M 2 ☐ F Director VIRGINIA 212**-**18-5435 85 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits r than "natural", or Itams 23a or 28a-f ahow 1 Tyes 2 No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4208 OAKFORD AVE. 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2\OXNo Specify: Specify: BLACK þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry markad other than Elementary/Secondary (0-12) College (1-4or 5+) -12--0-FOREMAN BETHLEHEM STEEL permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked other any injury or other traumatic event, 9068. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BRATLEY PRATT REBECCA LEE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4208 OAKFORD AVE. BALTIMORE, MARYLAND 21215 RUTH J.K. PRATT(WIFE) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 10-28-2004 1 □ Burial 2 □ Cremation
4 □ Donation 5 □ Sther (5 3 Removal from State 5 Denter (Specify) GARRISON FOREST VETERANS OWINGS MILLS, MARYLAND Funeral Service Licensee JONATHAN 21. Signature of D. HIBNER Name and Address of Facility REDD FUNERAL SERVICE 1721-27 N. MÖNRÜE ST. BALTIMÜRE, MARYLAND 21217 ب Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA Physician DAY /Medical Due to (or as a consequence of): **Examiner** DISEASE ARKINSON 15 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed UTI Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 ₽t/nknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has certificate 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification; To After this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred I or Attending Fafter death. 1/ Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospital within 24 hours a To the Funeral D 29a. Certifier 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

Registrar

Shacon Maca
31. Date filed (Month, Day, Year)

OCT 2.7 2004

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

20053150

067254

ELLICOTTCITY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiepe 34086 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 23 **Physician** OCTOBER GILBERT PEREL 2004 9:05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BRIGHTWOOD NURSING HOME LUTHERVILLE BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 07/16/1912 7. Age (In yrs. last birthday) **92** Yrs. Birthplace (State or Foreign Country) **Funeral** 218-32-0953 1**X** M 2□F Director MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itams 23a or 20-700. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE 1 ☐ Yes 2 No LUTHERVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 515 BRIGHTFIELD ROAD 21093 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ① No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. WHITE 1 Never Married 2 Married 1 ☐ Yes 2 1 No Specify þ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry WHOLESALE SHOE Elementary/Secondary (0-12) College (1-4or 5+) PROPRIETOR **BUSINESS** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be PEREL MORRIS MARY **SCHER** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARK H. PEREL SON 7219 PARKS HEIGHTS AVE. APT. 102 BALTO. MD 21208 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State BALTIMORE HEBREW 10/26/2004 REISTERSTOWN, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Total 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** DIABETES monuts MELLITUS /Medical Due to (or as a consequence of): Examiner DESTENTIA nontho Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and I for use as the burial-transit To the Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) be detached the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4. Unknown peeu 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? certificate 1 ☐ Yes 2 NO 1 TYes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient Certification: To 3□ DOA this To the Funeral Diractor; After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Hatural 1 Yes 2 No 2 Accident within 24 hours after deat To the Funeral Diractor; 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Puple MD D0053150 റു

Registrar DHMH 17 Rev 1/2001

State

M. D

22. Registrar's Signature

POBOX 6303,

ELLICOTTCITY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ShAWNMACA

31. Date filed (Month, Day, Year)
OCT 2 7 2004

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	1	For State Registrar	State	of Ma	arylan		artmen e <i>rtificat</i>				ental Hyg	iene	004	34087
Physicia /Medica	n	I. Decedent's Name (First, Middle BERNARD	Last)					PEAI	RLMAN	1	2. Date of Dea Month	th Day	Year 2004	3. Time of Death
Examine	r 4	a. Facility Name (If not institution, GOOM Sama)	ntan	1405	pit	al	B	ai-	Location	rore	B. Date of Rid		Ounty of Death	
Funeral Director		5. Social Security Number 220-30-5729	6. Sex 1 M 2 □ I		70	ast birthda Yrs.	Months	Days	Hours	Min.	8. Date of Birtl (Month, Day 05/14/1	934	9. Birti	nplace (State or Foreign untry) MD
show		Usual Residence of Decedent 10a. State 10b. County MD BALTIM	INDE		_ ′	Town or								10d. Inside City Limits 1 □ Yes 2 No
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fler death v	<u>a</u>	300 SALONY DRIV	12. Was D Ammed 1 1/1 Ye If Yes		EC	s. 13			spanic Oi n, Mexica Specify		city Yes or No- Rican, etc.)	14	S.A. Race - Ame Black, White pecify:	
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and 2 lealth a m 27 ls		ROSALIE PEARLMA	N/WIFE		20h P		SALON position (Na.		IVE /		211 REI		STOWN,	MD 21136
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permit. Departrimportrimports any inji		21. Signature of Funeral Service	icensee	till	ر لم	8					LEVINS DAD - P			MD 21208
Physician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a A	NO 7 e to (or as	a conseq	BRA	112	INJ	ury	s cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death 3.2 hours
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ate be nysicie	cai	resulting in death) Last	d	e to (or as	a conseq	uence of):								
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has has	Completed										24a. Was autor perfo		death?	utopsy findings available completion of cause of 2 No
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ng Phys after this aneral dii	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendir 2 Accident investi	28a. E	1 Mnpationate of Injuing Month, Da		28b. Time Injur		28c. Injur Wor	401	-	me 5 Resident			ciry)
	Certification:	3 Suicide 6 Could 4 Homicide determ	inod 206. F	Place of In ouilding, e	jury - At h tc. <i>(Speci</i> i	ome, farm, fy)	street, facto	ry, office			28f. Location (: City or To	Street and vn, State)	Number or Ri	ural Route Number,
Lothe Hospital within 24 hours of To the Funerel I completely filled	edical (29a. Certifier 1 Certifyin (Check only one) 2 Medical	ng Physician: T Examiner: On t and	o the best the basis o manner st	of examina	owledge, de ation and/o	eath occurred r investigation	at the tir n, in my c	ne, date a pinion, de	and place, a eath occurr	and due to the ed at the time,	cause(s) a date and p	ind manner as place, and due	s stated. a to the cause(s)
To th To th	Σ	29b. Signature and title of certifie			MD			RES	e numbe	0	(CTO		8 2004
*	1	30. Name and address of person CHAMION OLI	VIER M	D			<u></u>	OCH E	AVE		YAN HO VD. BA			5601 D 21239
Sta Registr	ar	31. Date filed (Month, Day, Year,		32. Regist	-	Ag	Spo	rels	/					

Registrar DHMH 17 Rev 1/2001

PEARL MAN

BERNARD

ORIGINAL

				For State of Maryland / State Registrar	Department of Health and Mer Certificate of Death	ntal Hygie ั ศ Reg. พ		34000
		O Dharaini		1. Decedent's Name (First, Middle, Last)	2.	Date of Death	ay Year	3. Time of Death
		Physici /Medic		Gladys Virginia Prescott		october o	20, 200	
U		Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	c. County of Deat	
		Francis		Upper Chesapeake Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last	Bel Air birthday) If Under 1 Year If Under 24 Hrs. 8	Date of Birth	Harfo 9. Birt	
		Funeral Director		168-26-1165 1□M 2XF 94	Months Days Hours Min.	Date of Birth (Month, Day, Year		hplace (State or Foreign untry) ryland
		pu 🔪		Usual Residence of Decedent	own or Location			10d. Inside City Limits
		Aaryla f sho	ō					1√2 Yes 2 □ No
5		death with the Maryland ims 23a or 28a-f show r must be notified at	Director	Maryland Harford Be	el Air 10f. Zip Code	10g. C	Citizen of What Co	ountry?
214		h with	ai Di	206 D Crocker Drive	21014		USA	
a		r dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto Rice	y Yes or No- an, etc.)	14. Race - Ame Black, White	
	36	72 hours after natural', or ita dical Exercine	by Fi	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 3 ☑ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2√2 No Specify:		Specify:	
	9	2 hou atura		15. Decedent's Education	6a. Decedent's Usual Occupation	16b.	Kind of Business/	<u>hite</u> Industry
	215	within 7. ene. than "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of working life. DO NOT use retired)			
	12	led wi lygien her th nt, Lee	Con	12	Medical Technician		alth Car	e
	anc	d be find Head of ced of	Be c	17. Father's Name (First, Middle, Last) John Henry Seeger	18. Mother's Name (F Laura Vi		rilghman	
1	Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If itam 27 is marked other than "natural", or itams 23a or 28a-1 show amy injury or other traumatic event, it a Madical Evortinet must be rediffed any injury or other traumatic event, it a Madical Evortinet must be rediffed at Once.	ို		19b. Mailing Address (Street and Number or Rural R	-		
104	Ĭ,	and 2 salth a n 27 is		Holly Greene / Daughter	214 Kings Crossing Cir	cle. Bel	Air. MD	21014
130/	ore	of He of He If itam or oth		1 ☐ Burial 2▼ Cremation 3 ☐ Removal from State	e of Disposition (Name of Date place)	9 20c.	Location - City or	Town, State
	Baltimore,	t. Pag tment tant: ijury o		`4 □Donation 5 □Other (Specify) Hill	top Service Corp. 10-23		wson, Ma	ryland
10	Bal	permit. Departr Imports any inje		21. Signature of Fundral Service Licensee Munus 4 - Mungs	22. Name and Address of Facility McComas Funeral Home 1317 Cokesbury Road,	Abingao:	n, Maryl	and 21009
				23a. Part1. Enter the disease, or completations that caused the death. I shock, or heart failure. List only one cruse on each line.	Do not enter the mode of dying, such as cardiac or re	espiratory arrest,		Approximate Interval Between Onset and Death
		Pnysician /Medical	ř I	Immediate Cause (Final disease or condition resulting in death)				
		Examiner		Due to (or as a consequen	vcinoma			Surs
		P =	ner	Sequentially list conditions, b. Due to for as a consequent cause. Enter Underlying Cause (Disease or injury				
V.	4	and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C Due to (or as a consequen	on of):			
51101	68760,	fficate be executed g physician and as the burial-transit	aE	Due to (of as a consequent	ca or ₎ .			
15	687	E 00 6	edical	Ö.				
5	Вох	The law requires that the death certifi ate has been signed by the attending I page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal de			23d. Date of del	,
7	O. B	that the death cer ed by the attendir detached for use	sicia	in the past 12 months? 1 Yes 2			Month	Day Year
\h	σ.	that the	Phy	Part II. Other significant conditions contributing to death but not resulting	ng in the underlying cause given in Part I.	23e. Did tobacco	use contribute to	the cause of death?
0	of Vital Records,	luires than signed I	Completed by	Age atrial fibrillation		1 □ Yes	2 □ √0 3 □ Pr	obably 4 Dunknown
1	000	law requii as been s 2 should	piete	1 / ***		24a. Was an	24b. Were at	itopsy findings available
Scot	R		mo			autopsy performed? 1 ☐ Yes 2 ☑ N	death?	completion of cause of 2⊞No
CC	/ita	iclan: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (C	Check only one)		
W	of	this al dii	5		/Outpatient 3 DOA Other: 4 Nursing Home	5 Residence d. Describe how inj		cify)
200	lon	nding F ith. : After s funer	tion	1 Polatural 5 Pending (Month, Day Year) 2 Accident investigation	b. Time of		,	
7	Division	l or Attendi after death. Diractor: A	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory, office 28f	Location (Street a		ural Route Number,
13,		pital or At ours after o aral Dirac						
360232		00 E E >	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination and manner stated.	dge, death occurred at the time, date and place, and place, and place, and place, and place and place, and place, and place and place, and place and place and place.	d due to the cause(at the time, date a	s) and manner as nd place, and due	s stated. to the cause(s)
4.0		To the Ho within 24 To the Fu completel	Me	29b. Signature and title of certifier	29c. License number		Date signed (Mont	*
		./		AR L. UV) MO	D47463	10c	tober 2	1,2004
	-	b		Scatt A. Stennetz Ms 520 Up/		el Aii, mi	7 2/014	
		St Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Some to			

State of Maryland / Department of Health and Mental Hygier 0 0 4 34089 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Clement John Rasel 22, 2004 2:00 AM October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 42 Reeds Run Road Harford Edgewood If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday Funera! Months 1(XM 2□ F 218-10-7253 Director June 20,1920 Maryland 84 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10b. County 10a State 28a-f show other traumatic avant, the Medical Expriner runst be notified at Middle River 1 ☐ Yes 2 ☐ No Director Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number With ö 21220 204 Trailways Road United States tems 23a Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Tyes 2 □ No Yes, Give 10 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 TNo Specify: Specify r res, Give Year or Dates: 1942-45 3 XWidowed 4 ☐ Divorced White natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City Maintenance 12 Years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental P int: If itam 27 Is marked of Catherine Schwerdt George Rasel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 42 Reeds Run Road Edgewood, Maryland Mr. Michael Rasel / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ō permit. Page Department of Important: If any injury or once. Holly Hill Mem. Gdns. 10/25/2004 Middle River, Maryland * 4 ☐ Donation 5 ☐ Other (Specity) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Lice (see 1922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final OF Physician GANCER LIVER disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the burial-transit Due to (or as a consequence of): Box 68760. The law requires that the death certificate be Physician/Medical use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) 4 Pregnant at time of death P.O. ed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. þ 2 No 3 Probably 4 Unknown 1 Tes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy performed 2 No 1 Yes Division of Vital 25. Was case referred to medical examiner? the Hospital or Attanding Physician: 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending death. investigation 1 Tes 2 🗌 No 2 Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a 1 🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P16619 Curlan Sour October 22, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE MD. 2/236 9940 FRANKLIN C.VERGARA- SOARES SQUARE DRIVE 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 27 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2004

		4	For State Registrar		State of M	aryland / De <i>C</i>	partment of P rtificate of	Health and Death	Mental Hy	gieng Reg. No.	004	34090
	Physicia		1. Decedent's Name (F	First, Middle, Last)				2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic	al i	Ella L.				1		October	25	2001	1:40 P M
	Examin	er	4a. Facility Name (If no)		or Location of Deat	ın		County of Death	1
	Funeral		5. Social Security Num		x 7. A	ge (In yrs. last birthda	Balt:	If Under 24 Hrs		th	9. Birth	nplace (State or Foreign
	Director		214-22-11	3/]M 2 X]F	92 Yrs.	Months Days	Hours Min.	Oct. 1	,1912	N.F	intry) \
	and ow		Usual Residence of De 10a. State 10	ob. County		10c. City, Town or	Location					10d. Inside City Limits
	ar death with the Marylan tems 23e or 28a-f show armust be notified at	tor	Md.	Baltim	ore	Ess	ex					1 ☐ Yes 2X No
	or 28s	Director	10e. Street and Number	ər			10f. Zip Code			10g. Citiz	en of What Cou	untry?
	ath wi	ral		la Capri			2122				USA	
5-0036	urs afte al', or l	by Funeral	11. Marital Status1 ☐ Never Married3 ☒ Widowed 4 [12. Was Decedent Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No	8. Was Decedent of If Yes, specify Cui 1 ☐ Yes 2 ☒ No		Specify Yes or No to Rican, etc.)	1	4. Race - Amer Black, White Specify: Whi	e, etc.
5-0	n 72 hours "natural", edicul Exa	etec	15 (Specify	only highest grad	ucation le completed)	16a. De (G	edent's Usual Occu ve kind of work done DO NOT use retire	pation during most of wo	rking	16b. Kin	nd of Business/l	ndustry
121	within ene. than	Completed	Elementary/Seconda	ary (0-12)	College (1-4or	5+)	iviter	90)		Maı	nufactu	ring
92	illed Hygi other	Be Co	12 yrs. 17. Father's Name (Fir	st, Middle, Last)			- V - CC-	18. Mother's Na	me (First, Middle	, Maiden S	Sumame)	
Jar	Menta Menta arked atic ev	To B	Oscar La	ammi				Helmi	Erikson	L		
Maryland 2121	2 sho		19a. Informant's Name Joan Fer		ype, Print) daught		iling Address (Stree					ip Code)
e,	1 and Health em 27		20a. Method of Dispos		daugnt	20b. Place of Dis	Villa Ca	-	Date ESSE		ation - City or T	Fown, State
Baitimore,	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturany injury or other traumatic event, Ite Mudical ones.		1 ☐ Burial 2 💥 0 `4 ☐ Donation 5 (Cremation 3 □I □ Other (Specify		cemetery, c	Crematory or other pile	, oct.	26 , 2004	Balt	timore	
Bai	permit Depar Impor any in		21. Signature of Fune	NE Inc	2	C	22. Name and Addi Connelly E 1110 Solle	uneral H	ome Of D	unda:	lk	
Ţ.				ailure. List only o	lications that cause ne cause on each	d the death. Do not						Approximate Interval Between
	Physician	k N	Immediate Cause (Fir disease or condition resulting in death)	nal	a	conses	d suite	ent t	milmo			Onset and Death
	/Medical- Examiner		1930King in Goatin	- (Due to (or a	s a consequence of):						
l.	7-19	Jer	Sequentially list condi if any, leading to imme	tions, ediate	b. Due to (or as	s a consequence of):						
1	ocuted nd transit	Examiner	Cause (Disease or injuthat initiated events resulting in death) Las	ury	c							
60,	ificate be executed g physician and as the burial-transit	al Ex	resulting in death) cas	°'	Due to (or a	s a consequence of):						
68760,	icate l physi s the b	edical			d							
P.O. Box	Attending Physician: The law requires that the death certif rdeath. r death. ector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use a	by Physician/M	IF FEMALE: 23b. Was decedent print the past 12 mo 1 ☐ Yes 2 ☐ N 9 ☐ Unknown	onths?		2 Fetal death	B □Ectopic pregnand of □ Other (specify)	су		2:	3d. Date of deliv Month	very Day Year
	juires that n signed b ild be deta		Part II. Other significa	ant conditions co	ntributing to death	but not resulting in the	underlying cause g	iven in Part I.		obacco us Yes 2 🗆		the cause of death?
Division of Vital Records,	The law red ate has bee page 2 shor	ompleted				-			24a. Was auto perfo 1 Yes		death?	copsy findings available ompletion of cause of
/ita	Physician: Th this certificate al director, pag	Be C	25. Was case referred examiner?	-	11				ath (Check only o			
of	Physic this c	T.	1 ☐ Yes 2 € No 27. Manner of Death)	Hospital: 1 ☐ Inpat 28a. Date of Inj	ient 2 ☐ ER/Outpat ury 28b. Time	ent 3 DOA		tome 5 Resi			in hospice
on	ding f h. After funer	tion		5 Pending investigation	(Month, D	ay Year) Injur	/ Wi	ork? ☐Yes 2☐No	200. Describe	now injury	Definación	
Divisi	l or Attendi after death. Director: A in by the fu	Certification;		6 Could not be determined	28e. Place of Ir	njury - At home, farm, etc. (Specify)			28f. Location (City or To		Number or Rui	ral Route Number,
_	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical Co	29a. Certifier 1{ (Check only one) 2[☑ Certifying Phy ☐ Medical Exam	/sician: To the bes iner: On the basis and manners	t of my knowledge, de of examination and/or	ath occurred at the investigation, in my	time, date and place opinion, death occ	e, and due to the urred at the time,	cause(s) a	and manner as place, and due	stated. to the cause(s)
_	To the within 2 To the complet	Me	29b. Signature and tip	te of certifier			29c. Licer	ise number		29d. Date	signed (Month	Day, Year)
				DN N	\sim		DH	D8541		10	125/	2007
	7		30. Name and address	- 0		death (Item 23a) (Typ	e, Print)	14.	6		1 /	
	V		31. Date filed (Month,	Par. Year)	32. Regis	ST Paul trar's Signature	PI BC	1timore	md.	2120	2	
*	Sta Registi		OC Date mos (Month)	T 2 7 200	34 /22	ital s signature	spork					

			For State Registrar	State of Maryland / De	epartment of Health and l Certificate of Death	Mental Hygier	
	Physici /Medic		1. Decedent's Name (First, Middle, Las JAMES Mad	12 0 0 1	Se.		20 Year 23.30 M
	Examir		4a. Facility Name (If not institution, give to the control of the	GONEKAL	4b. City, Town, or Location of Deatle	1	4c. County of Death HOWARD
	Funeral Director			20 F 83 Yr.	Months Days Hours Min	8. Date of Birth (Month, Day, Yes	9. Birthplace (State or Foreign
	ne Maryland Ba-f show	Director	10a. State 10b. County BAC	10c. City, Town of	DASUILLE		10d. Inside City Limits 1 ☐ 118 2 ☐ No
	ath with th	ral Dire	305 Hours	MANOR RD.	10f. Zip Code 21228		Citizen of What Country?
9036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23e or 28e-f show or other traumatic avant, the Medical Evantinar must be notified at	t by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 1 Yes 2 Not Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: BACK
21215-0036	d within 72 hujione. Jiene. r than "natu	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0·12)	de completed) (0	ecedent's Usual Occupation Sive kind of work done during most of work fe. DO NOT use retired) OU NSELOR	king	Kind of Business/Industry
Maryland ;	should be filed nd Mental Hygid s marked other umatic avant, I	To Be C	17 Fether's Name (First, Middle, Last)	Kobinson	Pober	ne (First, Middle, Maid	en Sumame) LISON
	1 and 2 she Health and em 27 is m		HELEN KOBINSE	N (WIFE) 30:	5 Howy MANOR	KD. CATO	y or Town, State, Zip Code) 21228 DNSCILLE MD
Baltimore,	Pa First Pa		20a. Method of Disposition 1 Surial 2 Cemation 3 4 Donation 9 Other (Specify 21. Signature Funeral Service Licen	AR BUT	isposition (Name of crematory of other place) U.S. Mem. PARILO - 2 22. Name and Address of Facility Re	16-04 B1	Location - City or Town, State TCTO. Marcy CANO
Ba	permit. Departm Importa any inju		farath	O. HiBre	1721-27 N. Mon	ROC ST.	BATO. MD. Approximate
	Pnysician /Medical Examiner	J. 6	Immediate Cause (Final disease or condition resulting in death)	a	epsis tase Menal 1		Interval Between Onset and Death
8760,	that the death certificate be executed of by the attending physician and detached for use as the burial-transit	dical Examiner	Sequentially list conditions, any leading list immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Africo (classe) Due to (or as a consequence of) d.	Tu Cardrova	ala j	Diplone
.O. Box 6	that the death certific ed by the attending p detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
ecords, P.	quires that on signed build be det	by	Part II. Other significant conditions of	ontributing to death but not resulting in th	ne underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
Vital Reco	tician: The law requires certificate has been sign rector, page 2 should be	e Completed	25. Was case referred to medical			24a. Was an autopsy performed	
of	di di	To B	examiner? 1 Yes 21 No 27. Manner of Death	Hospital: 1 Inpatient 2 ER/Outpa 28a. Date of Injury (Month, Day Year) 28b. Tim	atient 3 DOA Other: 4 Nursing H	ome 5 Residence 28d. Describe how in	
Division	I or Attending Phatter death. Diractor: After th	Certification;	1—Natural 5 Pending investigation 3 Suicide 6 Could not be determined		M 1 Yes 2 No	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	To the Hospital or, within 24 hours after To the Funeral Direction completely filled in E	Medical C	29a. Certifier (Check only one) Certifying Physical Example)	ysician: To the best of my knowledge, c liner: On the basis of examination and/o and manner stated.	leath occurred at the time, date and place or investigation, in my opinion, death occu	, and due to the cause rred at the time, date a	(s) and manner as stated. Indiplace, and due to the cause(s)
)	To the within To the compl	Me	29b. Signature and title of certifier	_	29c. License number) 3064-(29d. [Tohu 25 200 4
	10		30. Name and address of person who of the Merita Sa he	completed cause of death (Item 23a) (Ty	Back Now Neck	Road .	Toha 25 200 4 Br/home May land
• 41	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signature	ha K		, 4,24

		4	For State Registrar	State of Mar	•	artment of H <i>tificate of l</i>		rentai Hygier Reg. I	2004	34092
			1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		William Rufus F	000p				October 2	4, 2004	11:46 AM
	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Death		4c. County of Deat	h
			138 Brannan Road			Aber		0.0 (Dist.	Harfo	
	Funeral		5. Social Security Number 6. Sex	7. Age (M 2 ☐ F	(In yrs. last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea		hplace (State or Foreign untry)
	Director		219-22-2208 Usual Residence of Decedent		_77			Feb. 21,	1927 Vi	rginia
	and and		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Maryi f sho	Ď	Maryland Harfor	-d	Aberde	en en				1 ∐Yes 25K∑No
	28e	Director	10e. Street and Number	<u>. a</u>	TICLIAC	10f. Zip Code		10g.	Citizen of What Co	untry?
	3e of	Ö	138 Brannan Roa	ad		2	1001		USA	
	ms 2	Funerai		12. Was Decedent Ev Armed Forces?	ver in U.S. 13.	Was Decedent of H	ispanic Origin? (Sp	ecify Yes or No-	14. Race - Ame Black, Whit	
9	after or Ite	Ē	1 ☐ Never Married 2 X Married	1 XYes 2 No)	1 ☐ Yes 2 ဩ No	Specify:		Specify:	
5-0036	72 hours after death with the Maryland neturel; or Items 23e or 28e-1 show Jisal Examiner must be mailfied at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:				1		White
5-0	72 h 'netu	Completed	15. Decedent's Educ (Specify only highest grade	eation completed)	16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	ation during most of work	ing St	. Kind of Business/ ate of Ma	aryland
2121	within ene.	m	Elementary/Secondary (0-12)	College (1-4or 5+) !	k Driver	"			ransportation
2	filed v Hygie other t		17. Father's Name (First, Middle, Last)		III	K DITAGE	18. Mother's Nam	e (First, Middle, Maid	ien Sumame)	
anc	ould be t Mental I arked o etic eve	Be c	Rufus Roosevelt	z Roop			Virgie	e Virgini	a Bisho	o
Maryland	should nd Men marke umetic	ဥ	19a. Informant's Name/Relationship (Type		19b. Maili	ng Address (Street	and Number or Rui	ral Route Number, Cit	ty or Town, State, 2	Zip Code)
Na	0 0 0		Edna Roop / Wife		138	Brannon B	nad Abor	rdem. MD	21001	
ē,	Heal tem 2 other		20a. Method of Disposition		20b. Place of Dispo cemetery, cre	osition (Name of	pa)	Date 20c	. Location - City or	Town, State
9			1 ☑ Burial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)	emoval from State		Memorial		-27-04	Aberdee	n, Maryland
3altimore,	그 두 본 등		21. Sign of Fig. ral Service I census	96	2:	2 Name and Addre	ss of Facility	ome, P.A.		
m	Depare Depare Impor		114 HL CO	224/		1317 Coke	sbury Roa	ad, Abingd	on, Mary	land 21009
	7		23a Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the cause on each line	he death. Do not en	^				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Met	astatio	. Br	airs D	Sease	2/	Onset and Death
	/Medical		resulting in death)	Due to (or as a	consequence of):					
	Examiner		Sequentially list conditions,	o						
	ad sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					
/	and erran	хап	that initiated events resulting in death) Last	Due to (or as a	consequence of):					
68760,	The law requires that the death certificate be executed the has been signed by the attending physician and bace 2 should be detached for use as the burial-transit	edical Examiner								
387	icate phys s the	dic								
	leath certifi attending I I for use as		IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome o		70			23d. Date of de	livery
Box	death a atte	icial	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at t		□Ectopic pregnanc □ Other (specify) _			Month	Day Year
P.0	res that the de signed by the a f be detached t	Physician/M	9 🗆 Unknown	9□ Unknown						
	s tha	by P	Part II. Other significant conditions con	ntributing to death bu	t not resulting in the t	inderlying cause giv	ren in Part I.			the cause of death?
ğ	seen sig				·			1 ☐ Yes	2 2 No 3 □ P	robably 4 □Unknown
900	has be	Completed						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
Œ		mo.						performed 1 ☐ Yes 2 ☑		2 □ No
of Vital Records,	icien: Th certificate rector, pag	Be (25. Was case referred to medical examiner?					th (Check only one)	-	
≥ ×	Physic this co	2	1 ☐ Yes 2 No		nt 2 ☐ ER/Outpatie	RIL 3 DOA		ome 5 Nesidence 28d. Describe how i		ecify)
n 0	ng I	on:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injun (Month, Day	y 28b. Time (Year) Injury	Wo	rk? Yes 2 ⊟No	280. Describe now i	illury occurred	
Sic	Attendi death. ctor: A y the fu	cat	2 Accident investigation 3 Suicide 6 Could not be	28e Place of Inju	ry - At home, farm, s		103 2010	28f. Location (Stree	t and Number or R	ural Route Number,
Division	or Aratter of Direction by	Certification:	4 Homicide determined	building, etc	. (Specify)	root, tastory, omoo		City or Town, S	ita te)	
_	spital ours nerel filled			sician: To the best o	if my knowledge, dea	th occurred at the ti	me, date and place	, and due to the caus	e(s) and manner a	s stated.
	e Ho 124 h e Fui	edical	(Check only 2 Medical Exami	iner: On the basis of and manner star		nvestigation, in my	opinion, death occu	rred at the time, date	and place, and du	e to the cause(s)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Me	29b. Signature and title of certifier			29c. Licen			Date signed (Mon	th, Day, Year)
	1		Winam	MD		133	607	10	125/04	
	,/X\		30. Name and address of person who c	ompleted cause of de	eath (Item 23a) (Type	, Print)			1	
	15		Kamman M	Iham' Mx) -1106 R	evolution	o sit . He	arrelle G	rau M	1)2107 5
		ate	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	land.	,	arre De G		
	Regist	rar	OCT 2 7 2004	Clerk		aporas				

William

Months

Homemaker

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rock Run U.M. Cem.

23a. Pari1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

CONTRACTURES

SEPSIS

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death

OF UROSEPSIS

28a. Date of Injury (Month, Day Year)

CENTEAL DUSPITAGIA FROM CEREBRO-

4☐Pregnant at time of death

10f. Zip Code

21014

1 ☐ Yes 2 XNo Specify:

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

7. Age (In yrs. last birthday)

10c. City. Town or Location

Bel Air

74

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 Tho If Yes, Give Year or Dates:

College (1-4or 5+)

Whiteford
H Under 1 Year | If Under 24 Hrs.

Hours

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Marie

MCCOMAS Funeral Home, P.A.

CEREBEDVASCULAR ACCIDENT, OCD

3 Ectopic pregnancy

5 Other (specify)

Min.

Days

Physician /Medical **Examiner**

Country View Assisted Living
5. Social Security Number 6. Sex 7. Age (In vrs.

15. Decedent's Education (Specify only highest grade completed)

Lesieux

andow

10b. County

1419 Saratoga Drive

(unk)

19a. Informant's Name/Relationship (Type, Print)

4 Donation 5 Other (Specify)
21. Signal 19 15 peri Salvice Lensee

in the past 12 months? 1 ☐ Yes 2 ☐ No

1 Yes 2 No

1 Natural

2 Accident

3 🗍 Suicide

29a. Certifier

4 Homicide

(Check only one)

Chantal Marus / Daughter

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State

1 Never Married 2 Married

3 Widowed 4 □ Divorced

Elementary/Secondary (0-12)

12

17. Father's Name (First, Middle, Last)

Harford

213-52-9658 Usual Residence of Decedent

10e. Street and Number

10a. State

Maryland

Henri

20a. Method of Disposition

Directo

Completed by Funeral

1 ☐ M 250 F

Funeral Director

27 is marked other than "natural", or iteme 23a or 28a-f shov traumatic event, the Macical Examiner must be notified at d 2 should be filed within 72 th and Mental Hyglene. permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 Is m any Injury or other traum once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Physician/Medical Examiner þ Completed

To the Hospitel or Attending Physician: after death.

I Director: Aff within 24 hours a

anding physicien and use as the burial-transit

Certification: Medical

Division of Vital Records, P.O. Box 68760

Be

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 27. Manner of Death

VALARAU, PERFECTO C 32. Registrar's Signature 31. Date filed (Month, Day, Year) OCT 2 7 2004

5 Pending investigation

6 Could not be

of death (Item 23a) (Type, Print) H.O.

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

DØØ16389

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year) OCTOBER 25, 2004

Harford

10g. Citizen of What Country?

USA

Specify.

Own Home

16b. Kind of Business/Industry

20c. Location - City or Town, State

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

Month

23e. Did tobacco use contribute to the cause of death?

1 Tes 2 No 3 Probably 4 Munknown

Havre de Grace, MD

Approximate Interval Between Onset and Death

Year

France

14. Race - American Indian, Black, White, etc.

White

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Yes 2X No

8. Date of Birth (Month, Day, Year)

18. Mother's Name (First, Middle, Maiden Surname)

4112 Webster Road, Havre de Grace, Maryland 21078

1317 Cokesbury Road, Abingdon, Maryland 21009

(unk)

EXTREMITIES

(unk)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

10-26-04

SKIN VICERS, HANDS BIL

Sept. 6, 1930

1716 HARFORD RD SULLOG FALLSYON HO

24a. Was an autopsy

Other: 4 Nursing Home 5 Residence 6 Other (Specify) BOKE DIVE

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

26. Place of Death (Check only one)

DHMH 17 Rev 1/2001

State

Registrar

	1.	For State Registrar	State of Maryla	nd / Dep	artment of the rtificate of	Health and	Mental Hy	•	
Physician /Medical Examiner	4a	Decedent's Name (First, Middle, Las Charlotte Facility Name (If not institution, give JOHNS HOPKINS Social Security Number 6. Se	Street and number) Bayview x 7. Age (in yrs	. last birthday)	Sle 4b. City, Town, o Baltin	EGER or Location of Dea	2. Date of Deamonth Month ath	Ac. County of n/a	3. Time of Death
Director	10	15-09-9239 11 sual Residence of Decedent Da. State 10b. County MD n/a	10c. 0	5 Yrs. lity, Town or Le altimore			September	12,1909	Mary I and 10d. Inside City Limits 1 1 1 1 1 1 1 1 1 1
itter death with the Mark them 23a or 28a-fell of the must be notified.	10	De. Street and Number 600 S. Light Street,			10f. Zip Code 2123	30		10g. Citizen of Wh	
be fled within 72 hours after death with the wadylar be fled with Hydione. Ad other then "natural, or liema 23a or 28a-f show event, the Medical Examiner must be notified at event, the Medical Examiner must be notified at Re Completed by Firmeral Director	2	I. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1	Was Decedent of I If Yes, specify Cub		(Specify Yes or No- erto Rican, etc.)	- 14. Race - Black,	American Indian, White, etc. White
illed within 72 hours after death with the Maryland Hygiene. Inter then "natural", or itema 23a or 28a-f ehow int, the Madical Examination must be notified at a Commission by Euravai Director	_	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ccation de completed) College (1-4or 5+) N/a	(Give	dent's Usual Occup kind of work done DO NOT use retire	pation during most of w d)	vorking	16b. Kind of Busin	•
B is b	17		eide			Christi		Korn	
nit. Pages 1 and 2 should artment of Health and Mer ortent: If tiem 27 ie marke injury or other traumatic g.		9a. Informant's Name/Relationship (7 Ellen B. Nagle—daught Da. Method of Disposition	er	3609	Foster Ave	enue, Balt	Rural Route Numberimore, MD	ar, City or Town, St. 21224 20c. Location - Ci	
permit. Pages Department of I important: If its any injury or o ans.		1 Burial ACremation 3 1 Donation 5 Other (Specify) 1. Signature of Funeral Service License	Hi1	1top Ser	osition (Name of matory or other plate vice Corpored). Name and Address.	ration 10/	28/04	Towson, M	
any per		1/1/1/	With an a. Da	U	altimore, i			ford Rd.	rune at Tone
Physician /Medical Examiner	Ir d re	(3a. Part 1. Enter the disease, or comp shock, or heart failure. List only of mediate Cause (Final isease or condition soulting in death) equentially list conditions, any, leading to immediate	a. Septic Due to (or as a conse	Sho	·	ng, such as carol	ac or respiratory ar	rest,	Approximate Interval Between Onset and Death 24 hours
ed by the attending physician and detached for use as the burial-transit	3	ause. Enter Underlying ause (Diesele of injury lat initiated events soulting in death) Last	c	quence of):					
d by the attending physicians the process of the physician/Medic	1F 2:	FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fel 4 □ Pregnant at time of 9 □ Unknown	al death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of Month	
se pe pe	ה היינות ביות ביות ביות ביות ביות ביות ביות בי	art II. Other significant conditions co	ntributing to death but not re	sulting in the u	inderlying cause giv	ven in Part I.	23e. Did to	1	ute to the cause of death?
The law ate has b page 2 sl	_						24a. Was autop perfor 1 \sum Yes	sy prio rme _s d? dea	re autopsy findings available ir to completion of cause of th? Yes 2 No
ysician: Th is certificate director, pag	3	5. Was case referred to medical examiner?	Hospital: 'A.		Ot	200	eath (Check only of		
g Ph er th eral	1	1 ☐ Yes 2 € No 7. Manner of Death 1 € Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	of 28c. Injur	4 Indising	7	dence 6 Other ((Specify)
tai or Ar rs after c at Direc ed in by		3 Suicide 6 Could not be determined	building, etc. (Spec				City or Tow	m, State)	or Rural Route Number,
the Mospi nin 24 hou the Funer apletely fill		one)	sician: To the best of my kr iner: On the basis of examin and manner stated.	owledge, deat ation and/or in					
Withi To the		9b. Signature and title of sertifier	2	ONITAG	29c. Licens	se number		29d. Date signed (/	
15		0. Name and address of person who c	ompleted cause of death (Ite				R	10/26/	2004 RYLAND 2122
State Registrar	3	1. Date filed (Month, Day, Year) OCT 2 7 2004	32. Registrar's Sign	nature 4	South		UALTIN	all soon	14 TBUN 9199

Maryland / Department of Health and Me Certificate of Death	ental Hygiena 004	340	9
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N			For State Registrar	;	State of	i Maryla		artmen e <i>rtificat</i>			and M	lental Hy	giene Reg. No	UU) 4	340)95
			1. Decedent's Name (First, Middle	, Last)								2. Date of De Month		v	Year	3. Time	of Death
	Physici /Medic		Heath	er M	I. Sz	czepa	nik					Octobe	er 23	š, 2	004	0318	} M
	Examin		4a. Facility Name (If not institution			nber)		1		Location of	of Death		40.	,	of Death		
			Bayview Medical				to a februar		ltim	ore	24 Hrs	8. Date of Bi		n,		-1 (Canan	Familia
	Funeral Director		5. Social Security Number 218-13-7810	6. Sex	M 2√€	7. Age (In yr	21 Yrs.	Months		Hours	Min.	Month, Dec. 7	y, Year) , 19	82	Mar	place (State yland	3
	and		Usual Residence of Decedent 10a. State 10b. County			10c. (City, Town or	Location								10d. Inside (City Limits
	Manyl f sho ied s	ō	MD Bai	Ltim	ore			Bal	.tim	ore						1	s 2 🔀 No
	28a-	Director	10e. Street and Number					10f. Zip	Code				10g. Cit	tizen of \	What Cou	intry?	
	h with	Q E	8024 Eastda	le F	Road			2	122	4			US	Α			
	deat	Funeral	11. Marital Status	12	2. Was Dece	dent Ever in	U.S. 13	B. Was Dece	dent of H	ispanic Ori	gin? (Spo	city Yes or No Rican, etc.)	D-		e - Amer	ican Indian, , etc.	
2-0036	s within 72 hours after death with the Maryland liene. r than "natural", or Itams 23a or 28a-f show the Medical Examinat must be notified at	by	1 XNever Married 2 Married 3 Widowed 4 Divorced	ied	1 Tes If Yes, Giv Year or Da	/e		1 🗆 Yes		Specify:				Specif	Whit	e.	
בְּ	72 ho	sted	15. Deceden	's Educa	ation completed)		(Gi	cedent's Usu ve kind of wo	rk done	durina mosi	t of work	ing	16b. K	and of B	usiness/li	ndustry	
7	within lene. than "I	Completed	Elementary/Secondary (0-12)	J	College (1	-4or 5+)	- `life	. DO NOT u	se retired	1)				Sch	001		
7	illed w Hygier othar th	Co	12th 17. Father's Name (First, Middle,	(act)			S	tuder	t	18 Mothe	ar's Name	e (First, Middle					
Maryland	a la da la se	Be	Bruce Szczepa									a A. S					
Ž	s 1 and 2 should be f Health and Mental itam 27 Is markad othar traumatic av	To	19a. Informant's Name/Relations				19b. Ma	iling Address	s (Street			al Route Numb				p Code)	
<u> </u>	and 2 sho salth and n 27 Is m		Georgia Szc			/moth	er 8	024 E	Cast	dale	Roa	ad Bal	tim	ore	MD		
<u>ق</u>	s 1 ar if Hea itam othan		20a. Method of Disposition			20h	Place of Dis	position (Na.	me of	1		Date	-			own, State	
Baltimore,	permit. Pages Department of Important: If it any injury or o		20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 14 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetary, crematory or other place) St. Stanislaus 20c. Location - City of cemetary, crematory or other place) St. Stanislaus 10/26/04 Baltimon										more	MD			
	Physician /Medical Examiner		23a. Part 1. Enter the disease, o shock, or heart failure. Hist Immediate Cause (Final disease or condition resulting in death)	complic only one	S		win	enter the mod	de of dyin	ng, such as	V2	nelly Balti or respiratory a	more				ate etween
68760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. c.		(or as a cons											
0x 68	leath certificat attending phy for use as th	n/Medical	IF FEMALE: 23b. Was decedent pregnant	23		tcome of precont		3 □Ectopic p	regnancy						ite of deli	,	
P.O. B	that the death	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 ▼ Unknown			nant at time o		5 Other (s		·			1	М	onth	Day	Year
	quires that n signed b uld be deta	by	Part II. Other significant conditi	ons conf	ributing to d	leath but not	resulting in the	underlying	cause giv	en in Part I	l.			use con No		the cause of	
Division of Vital Records,	The law requir te has been si age 2 should I	ompleted										24a. Wa auto peri 1 Yes	opsy ormed?			opsy finding ompletion of	
ta	ian: rtifica stor, p	e C	25. Was case referred to medica	ıł						26. Place	e of Deat	h Check on					
>	Physician: r this certifica ral director,	To B	examiner? 1 🏹 Yes 2 🗌 No	H	ospital:	Inpatient 2	☐ ER/Outpa	tient 3 D	OA Ott	ner: 4□Ni	ursing Ho	me 5 🗆 Res	idence	6 □Oth	ner (Spec	ify)	
ion o	Attending PI r death. ector: After th by the funeral		27. Manner of Death 1 Natural 5 Pendi 2 Accident invest	ng igation	28a. Date Mon	of Injury of, Day Year	28b. Time Injur	У	28c. Injui Woi 1 🗀	ryat rk? ∣Yes 2. 🔀	(No	28d. Describe					
Divis	Hospital or Attanding Physician: The lav 44 hours after death. Funaral Director: After this certificate has tely filled in by the funeral director, page 2	Certification:	3 Suicide 6 Could determ				t home, farm, ecify)	street, factor	ry, office			28f. Location	(Street a	nd Numi	ber or Ru	ral Route Nu Del AVC	imber, TVL
	Hospital or 24 hours after Funaral Dire	dical (29a. Certifier 1 ☐ Certifyi (Check only one) 2 ☑ Medice	ng Phys Exemin	er: On the b	e best of my loasis of examiner stated.	knowledge, de ination and/or	eath occurred r investigation	d at the ti	me, date ar opinion, dea	nd place, ath occur	and due to the red at the time	cause(s	s) and m nd place,	anner as and due	stated. to the cause)(s)

State Registrar 29b. Signature and title of certifier

30. Name and address of pason who completed cause of death (Item 23a) (Type, Print)

TACK M. Tity M.D. 1111 Pe 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 0CT 2 7 2004

32. Registrar's Signature

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

October 23, 2004

		Ľ	1 - For State Registrar	State of Ma	ryland ,	Depa Cei	artment <i>rtificate</i>	of Heal	th and Mo ath	ental Hy	ygien Reg. No	004	34096
	Physicia	an	1. Decedent's Name (First, Middle, Last	1)						2. Date of D Month	Da		3. Time of Death
	/Medic Examin	al	Carolyn J. Smith 4a. Facility Name (If not institution, give	street and number)			4b. City. To	own, or Local	tion of Death	JCtos		County of Dea	7 77,10
	Examin	e.	ST Agnes/	1	TORR		RA	, .	2012		1	NA	ui
	Funeral		Social Security Number 6. Se		(In yrs. last	birthday)	If Under 1 Months		nder 24 Hrs.	8. Date of B (Month, D	irth (av. Year)	9. Bir	thplace (State or Foreign
	Director		248-66-3384 Usual Residence of Decedent		62	Yrs.				12-02-1	941		th Carolina
	yland Iow		10a. State 10b. County		10c. City, T	own or Lo	ocation						10d. Inside City Limits
	e Mar infed	ctor	MD NA			J	Baltimor	re					1 X Yes 2 □ No
	or 28	Dire	10e. Street and Number				10f, Zip C	ode			10g. Cit	izen of What C	ountry?
	eath v	eral	5313 Carriage Court	Apt A 12. Was Decedent E	ver in IIS	12.1		1229	Osisis2 (0sss			SA	
တ	within 72 hours after death with the Maryland ene. then "neturel", or items 23e or 28e-f show the Medical Evaluting Chinal Ce notified at	by Funeral Director	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔯 N					c Origin? (Spec xican, Puerto P	Rican, etc.)	10-	14. Race - Am Black, Whi	
000	urel', c	d by	3 ☐ Widowed 4 ₹ Divorced	If Yes, Give Year or Dates:	·		1 □ Yes 2 X		ecify:			Specify: Bla	ck
15-("netu	lete	15. Decedent's Edu (Specify only highest grad	ucation de <i>completed)</i>	1	(Give	dent's Usual (kind of work DO NOT use	done durina	most of workin	g	16b. K	ind of Business	/Industry
21215-0036	d withi	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)		Inspecto				Ţ	Varehouse	
b	al Hyg	Be C	17. Father's Name (First, Middle, Last)					18. N	lother's Name	(First, Middle	e, Maiden	Sumame)	
yla	Meni Meni Marke Maric	ဥ	William Cleckley							orie Bi			
Maryland	nd 2 st lth and 27 is r treum		19a. Informant's Name/Relationship (T) Anthony Smith/Son	ype, Print)					Avenue			r Town, State,	Zip Code)
	of Heal		20a. Method of Disposition				sition (Name natory or other			ite	т	ocation - City or	Town, State
Ë	Page ment c ent: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ F `4 ☐ Donation 5 ☐ Other (Specify,		Metro			or prace,	10-30-0	04	Cato	nsville,	MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturef", or items 23a or 28e-f show any injury or other treumatic event, the Medical Evantine must be notified at once.		21. Signature of Funeral Service Licens	1911	Α	1		Address of F		V. Gilm	or St.	Balto, 1	MD 21217
	-,-		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused to	the death. E								Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a. Ath	erosc	len	hic (ardie	o vascu	1/2-]	Isa:	se	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequen	ce of):							1
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	consequen	ce of):					<u> </u>		
V	and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c									
68760,	ifficate be executed g physician and as the burial-transit	al E	Tooling in dozin, 2001	Due to (or as a	consequen	ce of):							
687	ificate g phys	edlcal	•	d									
Box	attendin	an/N	230. Was decedent pregnant	23c. If yes, outcome o		ath 3	Ectopic pred	nancv			:	23d. Date of de	•
P.O. E	that the dealed by the all	Physician/M	in the past 12 menths? 1 □ Yes 2 DNo 9 □ Unknown	4□Pregnant at t 9□Unknown	ime of death	5 🗆	Other (spec	cify)				Month	Day Year
<u>.</u>	res that I	by Ph	Part II. Other significant conditions co	ntributing to death but	t not resultin	g in the ur	nderlying cau	ise given in P	art I.	23e. Did	tobacco u	se contribute to	the cause of death?
ords	w require been sig should b	ted t								1 🗆	Yes 2	□No 3□Pr	obably 4 Unknown
Vital Records,	e taw r has be	Completed								24a. Was	psy	prior to	itopsy findings available completion of cause of
a	n: Th fficate or, pag		25. Was case referred to medical							1 Yes	2 No	death? 1 ☐ Yes	2 No
⋚	ysicie s certi directo	o Be	evaminer?	Hospital:	t 2 MER/	Outnatien	t 3 DOA	04	lace of Death			3 □Other (Spe	oifu)
Division of	ng Ph fter thi	T :uc	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day	281	D. Time of Injury		: Injury at Work?		3d. Describe			ony)
isio	death. ctor: A y the fu	icatl	Accident investigation 3 Suicide 6 Could not be	29a Blace of Injur	A		М	1 Yes		Y 1	(0)		_
<u>></u>	afor A after I Direct	Certification:	4 ☐ Homicide determined	28e. Place of Injur building, etc.	(Specify)	, raimi, stre	eet, ractory, c	DΠICe	28	City or To	wn, State	a Number or Hu)	ıral Route Number,
	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriar-transit.	Medical C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of iner: On the basis of and manner state	examination	ige, death and/or inv	occurred at restigation, in	the time, date my opinion,	e and place, ar death occurred	nd due to the d at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	1 1				icense numb			29d. Dat	e signed (Monti	h, Day, Year)
}			30. Name and address of person who co	moleted source of the) N	10		JOOZ	7315)	Oct	ober	25, 2004
	5		MLFYU	llubor	-41 M	n (Type,	St	Ag	nes H	0100	tul,	Bul	Lahrence
**	Sta Registr		31. Date filed (Month, Day, Year) OCT 2 7 2	32. R distrar	Signature	k A	berte			/	(

			1- State of Maryland / Dep Registrar Ce	partment of Health and Mertificate of Death	ental Hygien	2004	34097		
H	Physicia	an	1. Decedent's Name (First, Middle, Last) Sydney O. Smith			ay Year	3. Time of Death		
	/Medic Examin	al	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		26 2004 c. County of Death	1:45 A ^M		
	EXAMINI	eı	Senior Constant Care	Sykesville		Carroll	,		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	/) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year		nplace (State or Foreign untry)		
l.	Director		360-07-7054 1 № 2 □ F 91 Yrs. Usual Residence of Decedent		May 12, 19	913 Ohio)		
	ified within 72 hours after death with the Maryland I Hygiene. other then "naturel", or items 23e or 28e-1 show yent, I've Medical Examiner must be notified at	Director	10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits		
			Maryland Carroll Sykesvill	Le			1 ∐Yes 2√∑No		
36		Dire	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Cou	untry?		
		erai	1200 W. Old Liberty Rd. 11. Marital Status 12. Was Decedent Ever in U.S. 13	21784		14. Race - Amer			
		To Be Completed by Funeral	Armed Forces? 1 Never Married 2 Married 1 XYes 2 No 144 Year or Dates: 1967	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto f 1 ☐ Yes 2 ☐ No Specify:	Rican, etc.)	Black, White			
Maryland 21215-0036			15. Decedent's Education 16a. Dec	edent's Usual Occupation	16b.	Kind of Business/l	ndustry		
21			Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of workir DO NOT use retired)					
12			17. Father's Name (First, Middle, Last)	ed States Army	(First, Middle, Maide		elligence		
an	× 2 2 9		Harry James Smith	Lillian M	,,	n oumame,			
ary	should and Men s marke umatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ling Address (Street and Number or Rura		or Town, State, Z	ip Code)		
	ss 1 and 2 should to f Health and Ment litem 27 is marked r other traumatic e			Sams Creek Rd. New		MD 21776			
lore	t. Page tment tent: If		I X bunal 2 □ Cremation 3 □ Removal from State	ematory or other place)		Location - City or T	Town, State		
Baltimore,				Forest Vet. Cem. 1		Owings M	ills, MD		
Ba	permi Depar Impor any ir		The fire poor	22. Name and Address of Facility urrier—Queen Funera 212 West Old Liber	cy ka. win	d Cremato ifield, M	ory, P.A. D 21784		
	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit and property of the funeral director.		233. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death						
			Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):						
		Physician/Medical Examiner							
			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause University in the University of the Control of the C				-		
			that initiated events resulting in death) Last C. Due to (or as a consequence of):						
68760,			5 5 6 (5 25 2 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5						
_			V .	v==					
Вох			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Voc 2 □ □ No. 1 □ Live birth 2 □ Fetal death 3 1 □ Voc 2 □ □ No. 1 □ Live birth 2 □ Fetal death 3 1 □ Voc 2 □ □ No. 1 □ Live birth 2 □ Fetal death 3 1 □ Voc 2 □ No.		23d. Date of delivery Month Day Year				
o.		hysic	1 Yes 2 No 9 Unknown 9 Unknown	Other (specify)					
S, D		by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?						
ord		Medical Certification: To Be Completed	Chronic upstouction	2 ZNo 3 □ Pro	bably 4 Unknown				
of Vital Record					24a. Was an autopsy performed?	prior to co	opsy findings available ompletion of cause of		
Vita			25. Was case referred to medical examiner? Hospital: Hospital:	26. Place of Death			A .		
			27. Manner of Death 28a, Date of Injury 28b, Time		ne 5 Residence 8d. Describe how inju		Wilststy (W		
ion			1-≝Natural 5 □ Pending (Month, Ďaý Year) Injury 2 □ Accident investigation	of 28c. Injury at 2 Work? M 1 ☐ Yes 2 ☐ No	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,	Junis		
Division			3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	ry - At home, farm, street, factory, office 28f. Loc (Specify)		cation (Street and Number or Rural Route Number, ty or Town, State)			
			29a. Certifier (Check only one) Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only one) Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
			29b. Signature and title of certifier	29c. License number	i i	ate signed (Month,			
)	. (I Chanles he Winsten	707610 Cm	10	1271	07		
	V		30. Name and address of person who completed cause of death (Item 2) (Type, Print) Charles trensgen, MD 410 Malcolm Dr. Ste. C Westminster, MD 21157						
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature OCT 2 7 2004 January & January						
			OUT ~ I LOUT APPROVE	awaren!					

State of Maryland / Department of Health and Mental Hygie e 0 34098 Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year **Physician** 1 cenne /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner If Under 24 Hrs. 8. Date of Right Birthplace (State or Foreign Country)
PA souside gren 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, 4/5/19 **Funeral** Months Days 1 □ M 200XF 199-16-9430 90 Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Director XX Yes 2 No MD St. Marys LEXINGTON PARK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21412 GREAT MILLS BLVD. 20653 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health end Mental Hygiene. Important: If item 27 is merked other then "natural", or Iten any Injury or other treumatic event. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes XX No Specify: WHITE Specify. \$ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BEAUTICIAN BEAUTY SHOP 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ CARL AMOROSO LILLIAN PASSARO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21990 CLIPPER DRIVE, GREAT MILLS, MD 20634 CARL AMOROSE - BROTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XX Burial 2 ☐ Cremation XX Removal from State WEST NEWTON CEMETRY 10/23/04 WEST NEWTON, PA 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Lic 22. Name and Address of Facility FINK FUNERAL HOME, PA 21. Signa 426 CRAIN HIGHWAY S., GLEN BURNIE, MD 21061 KELLY GREGORY #M01148 FINK enter the disease, or co cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner Prog the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a onsequence of) and Division of Vital Records, P.O. Box 68760 attending physician for use as the buria The law requires that the death certificate be Physician/Medical Due to (or as a consequence of) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Hotonown ٥ cate has been signification of the category and category. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? Completed 1 ☐ Yes 2 No 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Other: 4 Supring Home 5 ☐ Residence 6 ☐ Other (Specify) င္ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation s efter death.

If Diractor: Aft

ed in by the fur 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours a To the Funeral C completely filled 29a, Certifier CertifyIng Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: Or the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif JAMES BOYD, MD 30. Name and address of person who eted cause of death (Item 23a) (Type, Print) 4Wd Md 20636 to 22. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 16 Rev 6/95

Registrar

2.7 2004

State of Maryland / Department of Health and Mental Hygie () 34099 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 23, 12:45 P.º 2004 October Elizabeth Veronica Schloer /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Timonium 2520 Pot Springs Road, Apt 1A If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 M 2 F Yrs Sept. 4, 1923 Maryland Director 218-34-1542 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County s 23a or 28a-f show 1 ☐ Yes 2√ No Timonium Director Maryland Baltimore 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 21093 United States 2520 Pot Springs Road Pages 1 and 2 should be filed within 72 hours after death vant of Heath and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Itams 23 and viry or other traumatic avant, it a Medical Exertical and ury or other traumatic avant, it a Medical Exertical and Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian. Black, White, etc. 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) none -0none 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Julia Price Frank C. Schloer ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2520 Pot Springs Road, Timonium, MD Kathleen A. Yetz (friend) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition perrit. Pages 1 Department of H Important: If its any Injury or otl once. 1 ☐ Burial 2 XCremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Oct. 28, 2004 Baltimore, MD 21. Signatule of Funer / Service Licens re Chisholm Funeral Services of Dulaney Valley, P.A. Brian T. 200 E. Padonia Road, Timonium, MD 23a. Past Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caused line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Dyean /Medical **Examiner** ylan Sequentially list conditions, if any, leading to immediate cause. Enter Under in Cause (Disease or injury that initiated events resulting in death) Last Due to (or a / consequency/ f): Examiner the attending physician and ned for use as the burial-transit certificate be executed 0/61 Due to (or a a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☑ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 No 1 Yes Hospital or Attending Physician:
 24 hours after death.
 Funaral Diractor: After this certifies 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No funeral c Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification; 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the within 2 ofertifie 29b. Signature and title of 29d. Date signed (Month, Day, Year) D44793 Type, Print) Argue But MD 21222. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygie pen 0 4 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** SCHEIN SERDONE 20-19 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RANDAILSTOWN HESPITAL CENTER Confutors | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 04/05/1947 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign Country) Funeral 1 M 2□ F Director 220-46-5242 Usual Residence of Decedent death with the Maryland 10a State 10c. City, Town or Location 10h. County 10d. Inside City Limits , or items 23a or 28e-f show 1 ☐ Yes 2X No MD BALTIMORE RANDALLSTOWN Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8803 STEPHANIE ROAD 21133 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2/1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 Yes 2 No Completed by 3 ☐ Widowed 4 🂢 Divorced "naturel", 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done du life. DO NOT use retired) during most of working Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 4 **MASSAGE** THERAPIST MASSAGE 12 should be filed wind and Mental Hygien 7 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SCHEIN ELIZABETH PLOTKIN JACK ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: if item 27 is eny injury or other tra 25 STONE PINE COURT PIKESVILLE, MD 21208 HARVEY SCHEIN / BROTHER 20a. Method of Disposition
1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State HILLTOP SERVICE CORP 10/26/2004 TOWSON, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ESCHERICHIA Coh' disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off. Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, CIRAHOSIS WITH ASCITES 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☑ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy COAGULOPATHY performed 2010 Division of Vital 2 1 Yes the Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 ENO 1 Lipatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After 1 V Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours atter To the Funerel Direct 4 Homicide 1 Cortifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) NONTHWEST HESPITAL CANDAVISTONIAND 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bo CONANA wy) ORIANDO 31. Date filed (Month, Day, Year)

OCT 2. 7 2004 32. Registrar's Signature Registrar

State of Maryland / Department of Health and Mental Hygien 0 0 4 34101 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 4. 40 AM SAULOVITZ **Physician** Octobec SIDNEY 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death give street and number) 4a. Facility Name (If not institution **Examiner** RANDALLSTOWN OPTHWEST HOSP ITAL BAUTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth Month Day, Year 12/23/1919 Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Sociel Security Number 6. Sex **Funeral** 1 ☑ M 2 □ F 84 216-20-6519 MD Director Usual Residence of Decedent Peges 1 end 2 should be filed within 72 hours effer deeth with the Maryland nent of Heatth and Mental Hygiene. snt: If item 27 is marked other then "natural", or Iteme 23a or 28a-f ehow ary or other traumatic event, it a M-orical Examinar must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No Director MD BALTIMORE PIKESVILLE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. #7 21208 2 POMONA WEST APT. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 11. Marital Status Black, White, etc. 1 Never Married 2 Married WHITE 1 Yes 2 No Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 18b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) PROPRIETOR PHARMACIST PHARMACY 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be HONESBERG SMULOVITZ FRIEDA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2 POMONA WEST APT. #7 PIKESVILLE, MD 21208 LIBBY SMULOVITZ / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition
1 △ Burial 2 □ Cremation 3 □ Removal from State permit. Pege Depertment of Important: If any injury or once. 10/25/2004 ROSEDALE, MD RODFE ZEDEK * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) THEROSLERUTTL CARDIOVASCULAR **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ur as a consequence of) Examiner to the Hospital or Attending Physicien: The law requires that the death certificate be executed the attending physicien and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year ō 5 Other (specify) 9 Unknown δ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 3 Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 2 No 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 27. Mary er of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred filled in by the funeral After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a To the Funeral D 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of dertifier D43481 OLTOBER 23, 2004 \mathcal{V} of person who completed cause of death (Item 23a) (Type, Print) RANDAUSTOWN MARYLAND 120 5401 OUD COUPT 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Docks OCT 2 7 2004 Registrar

State of Maryland / Department of Health and Mental Hygiepen n [1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 24,_ 1:40P M John W. Sherrill, Sr. October 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sollers Point Road Dundalk Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 10**X**M 2□ F Yrs Director 215**-**22-0290 78 Maryland Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Exarcher must be notified at Md. Baltimore Dundalk Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 3559 McShane Way or Items 23a 21222 USA 12. Was Decedent Ever in U.S. Armed Forces? 15 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White þ 3 Widowed 4 Divorced Year or Dates: WW II natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) d 2 should be filed w h and Mental Hygier 7 is marked other th Pipe Fitter Beth Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be Deportment of Health and Mental Important: If item 27 is marked c any injury or other traumatic ewe once. Mark Sherrill Marie Kastner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte Sherrill/Wife 3559 McShane Way Baltimore, Md. 21222 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 14 □ Donation 5 □ Other (Specify) Sacred Heart of Mary Oct. 28, 2004 Baltimore, Md. 22. Name and Address of Facilit Kaczorowski Funeral Home, PA 21. Signature of Funeral Ser vli 1201 Dundalk Ave. Baltimore, Md. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician Congestive Heart Failure disease or condition resulting in death) /Medical Due to as a consequence of): Examiner oronary Artery Disease Sequentially list conditions, if any, leading to limit affatts cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed physician and the burial-transit iabetes that initiated events resulting in death) Last ue to (or as a consequence of) Box 68760, Physiclan/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month 4☐Pregnant at time of death Day Year 5 Other (specify) P.0. signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by Sibrillation 1X Yes 2 No 3 Probably 4 Unknown obstructive lung disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 XNo Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4□ Nursing Home 5□ Residence 6 Nother (Specify) Home S Certification: To 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death Diractor: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide filled 24 hours a 1 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 ho

To the Function 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) October 26, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Towson, Maryland 21204 7801 York Rd, Swite 224, Carol Newill MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

State of Maryland / Department of Health and Mental Hygier 004 34103 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Turner, Jr. Russell L. 1:33 PM M October 25. /Medical 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Johns Hopkins Bayview Medical Ctr. Baltimore City
| If Under 1 Year | If Under 24 Hrs. | 8.
| Months | Days | Hours | Min. | 8. N/A 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Yrs. Director 216-36-1852 Sept. 18,1938 West Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or iteme 23e or 28e-f show any injury or other treumetic event, If a Medical Exercitive I must be notified to once. 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Dundalk 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 7412 Alvah Avenue Apt. A 21222 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 TYYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Truck Driver Trucking Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Russell L. Turner, Sr. Ruby E. Hartman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Sharon Turner Wife 7412 Alvah Avenue Apt. A Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Hilltop Service 10/27/2004 Towson, Maryland Sixature of Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 29a: Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician CELL LUNG CANCER SMALL disease or condition resulting in death) 60 DAYS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner cartificate be axecuted the attending physician and had for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 4∏Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 2 No Physicien: 25. Was case referred to medical Be 26. Place of Death Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 Inpatient 2 X ER/Outpatient 3 IDOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death Hospital or Attending Pl
 A hours after death.
 Funerel Director: After to Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) L. Anueadha M.D. P15983 OCTOBER, 26, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD-21201 ANURADHA LINGAM. 22 , S. GREENE ST. BALTIMORE. 31. Date filed (Month, Day, Year) 32. Registrar's Signature OCT 2 7 2004 Registrar

State of Maryland / Department of Health and Mental Hygiere) 1 - Stete Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** William T. Truitt October 24, 2004 11:17% /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1X M 2 ☐ F 231-34-6157 Director 73 Aug. 14, 1931 Virginia Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir then "netural", or Items 23e or 28e-f show the Medical Examiner must be notified at FLMarion Ocala 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11035 Southwest 64th Ave. 34476 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 22 No Specify: þ Specify hite 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Construction Elementary/Secondary (0-12) College (1-4or 5+) Master Carpenter 12 should be filed w h and Mental Hygier 7 Is marked other th 11th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Bryan Truitt Delda Irene Wiley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Importent: If item 27 Is any injury or other treu Once. Patricia Truitt /wife 11035Southwest 64th Ave. Ocala FL34476 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 10/26/04 Baltimore MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ConnellyFuneralHomeofEssex 21. Signature of Funeral Service Licensee 300 Mace Ave. Baltimore MD 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) AcutE **Physician** INTARCTION MVOCARBIAL /Medical Due to (or as a consequence of): Examiner PERTENSION Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua for as a consequence of): Examine Due to (or as a consequence of): Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 ☑ No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 3 Suicide 6 ☐ Could not be within 24 hours after de To the Funeral Directo completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MD 72/674 OCTOBER 26,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MADTES KEVIN 501 S.UnionAve. Havre de Grace MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 2 7 2004 Registrar

DHMH 17 Rev 1/2001

Box 68760

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Records, P.

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Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 10 14 34105 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** William James Vlangas October 22. 2004 /Medical 3:00 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 5415 Bangert Street White Marsh Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Days 1 M 2 □ F Months Hours Director Yrs 213-52-8892 17, 56 May 1948 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene.

and: If item 27 is marked other than "neturel; or Items 23a or 28a-1 show thy or other transite in this case." 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Maruland Baltimore White Marsh 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5415 Bangert Street 21162 u. s. A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2 Years Teacher <u>Automotive Technology</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဂ္ James William Vlanaas Mary Louise Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JoAnna Vlangas (Wife) 5415 Bangert Street, White Marsh, Maryland 21162 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gardens 10/25/2004 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 9705 Belair Road, Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician FAILURE CONGESTIVE 5 YEARS HEART disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 10 YEARS COPONARY ARTERY DISEASE Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence or) requires that the death certificate be executed burial-transit HYPERTENSION 15 YEARS Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medicai the use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ OBESI 1 ☐ Yes 2 ☐ Ho 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗌 Yeş 2 Ne 1 ☐ Yes 2 ☐ No To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Desidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending investigation Injury 1 TYes 2 □ No s after death 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 To the 29b. Signature and title of certifier License number 29d. Date signed (Month, Day, Year) 1/2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

32 Registrar's Signature

			For State Registrar	te of Maryland / Do	epartment of H Dertificate of	lealth and I Death		2004	34106
	Physici		1. Decedent's Name (First, Middle, Last)	·	WHITL	EY	2. Date of Death Month	Day Year	3. Time of Death 4 02:42 AM
	/Medio Examir		4a. Facility Name (If not institution, give street a Tohns Hopkins	Hospital	4b. City, Town, o	LES mo	relity	4c. County of Death	·
	Funeral Director		5. Social Security Number 219–38–1966 Usual Residence of Decedent	7. Age (In yrs. last birth	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Sirth (Month, Day, Y September 2	ear) Cor	nplace (State or Foreign intry)
, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Show the contracts: If them 27 is marked other than "naturel", or Items 23e or 28e-f show any njury or other traumetic event, I'm Medical Evander invatile rodified at once.	To Be Completed by Funeral Director	10a. State 10b. County MD. Baltimore	10c. City, Town of Dunda					10d. Inside City Limits 1 ☐ Yes 2 📉No
			10e. Street and Number 2802 Moorgate Road		10f. Zip Code	21222	10g	Citizen of What Cou	intry?
			11. Marital Status 1 Never Married 2 Married 1 Nover Married 2 Married	Decedent Ever in U.S. ed Forces? Yes 2 \(\sum \) No ss, Give r or Dates:	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🌠 No		pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White	
			15. Decedent's Education (Specify only highest grade comp. Elementary/Secondary (0-12) Coll 12 years	eted) (6 lege (1-4or 5+)	decedent's Usual Occup Give kind of work done ife. DO NOT use retired rd Superind	during most of wor d)	king	b. Kind of Business/li	
			17. Father's Name (First, Middle, Last) Earl Whitley				ne (First, Middle, Ma ne Walker	iden Sumame)	
	as 1 and 2 sho of Health and item 27 is my r other traume		19a. Informant's Name/Relationship (Type, Prir Judy Whitley Wif	e 280	Mailing Address (Street of 2 Moorgate	and Number or Ru Road, D	rai Route Number, C undalk, MD.	ify or Town, State, Zi 21222	p Code)
Baltimore,	Pages 1 ment of He ant: If iter ury or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal 4 Donation 5 Other (Specify)	from State cemetery,	Disposition (Name of crematory or other place of the Crematory		ber 28,	c. Location - City or T altimore C	
Balt	permit. Page Depertment Important: If any njury or		21. Signature of Funeral Service Licenseen	Connelly	Connelly F 7110 Solle	ss of Facility uneral H	Ome Of Dur	ndalk,P.A.	
	Prysician /Medical Examiner	Medical Certification: To Be Completed by Physician/Medical Examiner	Sequentially list conditions.	that caused the death. Do but a neach line. Let More than the consequence of the consequ	gic po	g, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death Out Months
Division of Vital Records, P.O. Box 68760,	icate be executed physician and s the burial-transit		that initiated events c.	te to (or as a consequence of)		xilure			IWO months
	res that the death certificing of the attending for detached for use as		in the past 12 months?	s, outcome of pregnancy Live birth 2 Fetal death Pregnant at time of death Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of deliv Month	ery Day Year
	Hospital or Attending Physician: The law requint A hours after death. Funerel Director: After this certificate has been sely filled in by the funeral director, page 2 should		Part II. Other significant conditions contribution Status post		ne underlying cause give		23e. Did tobac 1 ☐ Yes	co use contribute to t	he cause of death?
							24a. Was an autopsy performed	prior to co death?	opsy findings available impletion of cause of
			25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury Mork? M 1 Yes 2 No		ome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred			
			3 Suicide 6 Could not be determined 28e.			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
			(Check only 2 Medical Examiner: On one) and	o the best of my knowledge, d the basis of examination and/o manner stated.	leath occurred at the time or investigation, in my or	ne, date and place, pinion, death occur	and due to the cause red at the time, date	e(s) and manner as s and place, and due to	tated. o the cause(s)
	To the within 2 To the complet		29b. Signature and title of certifier W. Asiano , A	40		-000	00	Date signed (Month,	,2004
	10	iso:		1 11 1	pe, Print) To	600N. in	Docto Voifesta	es Loun Baltimore,	ge, MO 21287
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature	tood.				

1- State of Maryland / Department of Health and Mental Hygie 20 0 4 tas Certificate of Death MAN 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** October 21, 2004 Ellen Marie Williams 2009 Р м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford 1731-A Fountain Rock Way Edgewood 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2√2 F 217-62-4764 51 Director Dec. 15, 1952 Md. Usual Residence of Decedent death with the Maryland r then "natural", or Items 23e or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Harford Md. Edgewood Director 1 ☐ Yes 為☐ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1731-A Fountain Rock Way 21040 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after ∏Yes 2**X** No f Yes, Give 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2√2 No Specity: White 3 Widowed 4 Divorced Specify: Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: if item 27 is marked other then any injury or other treumatic event Elementary/Secondary (0-12) College (1-4or 5+) 12 yrs. Home Housewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert James LaRock Violet Ester Lambert 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Williams husband 1731-A Fountain Rock Way Edgewood Md. 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 MCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oct. 26, Bayview Crematory Baltimore 2004 21. Signature of Europe I Service Vigenses Connelly Funeral Home Of Dundalk 7110 Sollers point Rd. 21222 23a/Par1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Complications of Chronic Alcoholism /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dualto (or as a consequence of). executed burial-transit Due to (or as a consequence of): P.O. Box 68760 attending physician The law requires that the death certificate be Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy or in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 4☐Pregnant at time of death Day 5 Other (specify) the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🐧 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed: death? certificate 1 Yes Division of Vital 2 🗆 No 2 🗆 No Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) At SCENE Hospital: 2 1X Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After To the Hospital or Attending 5 Pending investigation 1 Natural Injury s after death.
I Director: Aft
d in by the fur Accident 1 ☐ Yes 2 ☐ No 6 □ Could not be 3 🗋 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 22, 2004 d cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

Whid 2. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiens Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** WRIGHT Month JEREMIAH 6:30 2004 OCTOBER 25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE CITY JOHNI HOPKINS HOSPITAL If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 14 M 2 F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye 04-24-1950 Birthplace (State or Foreign Country) **Funeral** Days 214-54-5678 Director 54 Yrs North Carolina Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. snt: If item 27 is marked other then "neturet", or Items 23e or 28e-1 show 10a State 10b County 10c. City, Town or Location rel", or items 23e or 28e-f show Examiner must be notified at 10d. Inside City Limits Director 1 XYes 2 No NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2001 Payson Street 21217 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 2No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No 2 3 ☐ Widowed 4 ☐ Divorced **Black** Completed treumetic event, the Wedical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Johnny T. Wright Mattie L. Wright ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Helen D. Rivers-Wright 2001 N. Payson Street Baltimore, MD 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1X Burial 2 □ Cremation 3 □ Removal from State 20c. Location - City or Town, State permit. Pages
Department of F
Importent: If ite
eny injury or ot
once. King Memorial Park 10-30-04 ^¹ 4 □ Donation 5 □ Other (Specify) Kandallstowe, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home 638 N. Gilmor St. Balto, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician HYPOXEMIA 20 disease or condition resulting in death) MINUTES /Medical Due to (or as a consequence of): **Examiner** MULTILOBAR PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine use as the burial-transit NON-SMALL CELL LUNG CANCER MONTHS or Attending Physicien: The law requires that the death certificate be exect Due to (or as a consequence of): Box 68760. physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy ó in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. the detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ page 2 should Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Whas an autopsy performe 2 X No 2 No 1 ☐ Yes director, Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To Inpatient 2 ER/Outpatient 3 DOA ihis funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature and title of centries 29c. License number 29d. Date signed (Month, Day, Year) D0062144 GERBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gerbeie Battimore, Md 600 North Wolfe St. 31. Date filed (Month, Day, Year) 32. Regular's Signature State OCT 2 7 2004 Registrar

Registrar DHMH 17 Rev 1/2001

State

To the within 2 To tha (Check only one)

29b. Signature and title of certifier

Humell

Pamela E. Southall

DOUTHALL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7 2004

32. Regis ar's Signature

Claser

2x Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

October 20, 2004

State of Maryland / Department of Health and Mental Hygien 2004 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death OCTOBER 22, 2004 **Physician** JEAN **GWYNN** WEBSTER 7:15 РМ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL MILLENIUM NURSING AND REHAB MARLEY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/24/1924 Birthplace (State or Foreign Country)
 MARYLAND 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2XXF 79 217-20-4183 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "neturel", or Items 23s or 28s-f shov the Medical Examinar must be notified at ANNE ARUNDEL GLEN BURNIE 1 Yes 2 No Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6654 ROBERTS COURT, APT 128 21061 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No WHITE Specify: Specify: þ ¾(X)Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY LAW 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be s 1 and 2 should be fi f Health and Mental H item 27 Is marked otl other traumetic ever EDGAR PERCIVAL GWYNN LILLY MAE BEAN 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 Is
eny injury or other trau DOROTHY M. ROCKEL - P.R. 301 BALTIMORE AVENUE SW., GLEN BURNIE, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 XXremation 3 Removal from State 10/26/2004 BALTIMORE, MD BAYVIEW CREMATORY ⁴ □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FINK FUNERAL HOME, PA GREGOR FLNK 426 CRAIN HICHWAY S., CLEN BURNIE, MD 21061 #M01148 23a. Part1. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail, re. List only one cause on each line. Approximate Interval Between Onset and Death re. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) alcinoma **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that in:trated events resulting in death) Last Due to or as a consequence of Examiner burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months?
1 Yes 2 No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed Quelle 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate has autopsy 1 Yes Hospital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of leat 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation death. 1 🗌 Yes 2 🗌 No after death Director: 3 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature nd title of certifier ss of person who completed cause of death (Item 23a) (Type, Print) 6000 RIDGELY THE STEZZI TONAPOLIS, MD. 21401 Seein & Aprile OCT 2 7 2004 Registrar

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State	e of	Mary	land /	Depa	rtment	of H	lealth	and	Me	ntal	Hyg	jien

04-06709 RPD	•	For State Registrar	State of Marylan		artment rtificate			and M	ental Hy	/giene Rag. No	2	0.1	<u> </u>
Physicia /Medica		Decedent's Name (First, Middle, Last Langford Woodhou	se						2. Date of D Month OCTOR	er I			3 jirl∔of Death 1211 P M
Examine	r	4a. Facility Name (If not institution, give Johns Hopkins Hos	pital	last hirthday	4b. City, To Balti	more			2 Pate of D		County of		(0)
Funeral Director		5. Social Security Number 6. Se 220-64-0851 Usual Residence of Decedent	× 7. Age (In yrs. 49	Yrs.		Days	Hours	Min.	8. Date of 8i (Month, D 08/12/			9. Birthpi Coun Mary	,
ath with the Maryland 23a or 28a-f show wat be notified at	ctor	10a. State 10b. County Md N/A		y,TownorLo 1 timor								10	0d. Inside City Limits 1 → Yes 2 □ No
with the	i Director	10e. Street and Number 622 S. Monroe Str	eet		10f. Zip C					10g. Ci	itizen of W	hat Coun	try?
er des Items	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Moroced	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			ent of His by Cuban	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto l	cify Yes or N Rican, etc.)		14. Race	- America c, White, c	etc.
15-003	Completed	15. Decedent's Ed (Specify only highest grad		(Give	dent's Usual kind of work DO NOT use	done du	uring most	t of worki	ng	16b. K	Kind of Bu		
Maryland 21215-0	omo;	Elementary/Secondary (0-12)	College (1-4or 5+)	N/A						N/			
and the file and other event	Be	17. Father's Name (First, Middle, Last)							(First, Middle		n Sumam	e)	
aryld should and Me s mark umatic	<u>P</u>	Langford Woodhous 19a. Informant's Name/Relationship (7		19b. Maili	ng Address (Street a			Smith I Route Numi		or Town,	State, Zip	Code)
ore, Marylan pes 1 and 2 should b tof Health and Ment if Itam 27 is marked or other traumatic e		Toinette Woodhous		622 Place of Dispo			e Str		Balti ate		, Ma:		nd 21223
Baltimore, I permit Pages 1 and Department of Healt Important: If Item 2 any injury or other ones		1 Burial 2 Cremation 3 1 Donation 5 Other (Specify 21. Signature of Funeral Service, Licental Service, Licental Service, Licental Service, Company Shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Crease of the Service S	Mt see Milications that caused the deat one cause on each line.	h. Do not end uence of):	2. Name and 00 S.	Address	s of Facility	y W i s 1d A	e Fune ve Ba	ral lt i m	Serv:	ices	Maryland P.A. Pland 21229 Approximate Interval Between Onset and Death
O. Box 687 It the death certificate by the attending phy: tached for use as the	Physician/Medical	in the past 12 months? 1 Yes 2 No 9 Unknown	d	I death 3[eath 5[⊒Ectopic pred □ Other (sped	cify)					23d. Date Mon	th	Day Year
ds, Fuires that signed and the definition of the	þ	Part II. Other significant conditions of	intributing to death but not res	ulting in the u	nderlying cau	use give	n in Part I.		1				e cause of death? ably 4 Unknown
Vital Records, sician: The law requires to certificate has been signer rector, page 2 should be or	Completed								24a. Was auto perf 1 [A Yes		p d	/ere autoprior to consath?	osy findings available apletion of cause of
Vital Fician: The certificate	Be	25. Was case referred to medical examiner?	Hospital:			Other			(Check only				
thy hy	n; To	27. Manner of Death	1 ☐ Inpatient 2X 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury		c. injury Work			ne 5 🗆 Res 8d. Describe)
or Al	Certification;	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	10/17/04	11:28	A M reet, factory,	1 🗆 Y	es 2 X	2	Subject 281. Location City or To	wn, State	nd Numbe		ter Route Number, Ito atm. MD
DIVI To the Hospital or At within 24 hours atter or To the Funeral Diract completely filled in by	Medical C	(Check only 2 Medical Exem	sicien: To the best of my kno iner: On the basis of examina	wledge, deat	h occurred at	t the time	e, date and inion, deat	d place, a	ind due to the	cause(s) and mar	ner as sta	ated.
To the within 2 To tha complet	Med	29b. Signature and title of certifier	and manner stated.		29c.	License	number			29d. Da	ate signed	(Month, L	Day, Year)
		· famen fouth	a4,mD			C.M.	.E.			Oct	ober	18,	2004
\mathcal{V}		30. Name and address of person who of Pormela E. Southa.	completed cause of death (Item			ın St	treet	, Ba	ltimor	e, M	aryla	and 2	21201

Registrar

OCT 2 7 2004 Signature of Species

			1 - For State Registrar	State of Marylan	d / Depa <i>Cei</i>	artment of He rtificate of D	ealth and M Death	ental Hygier Reg. N		34112
			1. Decedent's Name (First, Middle, Las	t)				2. Date of Death		3. Time of Death
	Physicia /Medic		STEPHANIE	LOTA WE	12500			- A	ay Year	3:50 PM
	Examin		4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death	4	c. County of Dea	ath
			1936 FALLSTEN V			FALLST	10		MARF	580
	Funeral		5. Social Security Number 6. So	TH DATE	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea	(r)	rthplace (State or Foreign ountry)
	Director		Usual Residence of Decedent	35	113.			LEC: 14 10	Pd 1.14	RYLAND
	yland		10a. State 10b. County	10c. City	, Town or Lo	ocation				10d. Inside City Limits
	Mar Me-f st	tor	Marriano HARFE	RO F	AUST	29				1 ☐ Yes 2 No
	or 28	ire	10e. Street and Number			10f, Zip Code		10g. (Citizen of What C	ountry?
	23a	rai	1936 FAULTON	VALLEY ORIVE		210	47		U.S.A.	
	tems	Funeral Directo	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of His f Yes, specify Cuban	panic Origin? (Spe , Mexican, Puerto f	cify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
36	rs aft	by F	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2█ No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify:	112
21215-0036	72 hours after death with the Maryland natural', or Items 23a or 28e-f show dical Examinar must be notified at	ted	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occupat	tion	16b.	Kind of Business	/Industry
215	within 7; iene. than "n	pie	(Specify only highest gra-	de completed) College (1-4or 5+)	(Give life. i	kind of work done du DO NOT use retired)	uring most of workir	19		,
2	e filed within the Hygiene. other than vent, the M	Completed	13482	BYRS.	Ho	MEMAKE	R		AT Ho	3ng
nd	be fill tal Hy d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, Maide	en Sumame)	
yla	should be nd Mental marked o	5	DONALO	7017			PACA	TUCKER	3	
Maryland	0 6 8 8		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailir	ng Address (Street ar	nd Number or Rura	Route Number, City	or Town, State,	Zip Code) 21047
	1 and 2 Health em 27		20a. Method of Disposition	20b. Pl	ace of Dispo	sition (Name of	NATTEN!	ate 20c.	Location - City or	Town, State
altimore,	or = ro		1 Burial 2 Cremation 3 \(\) 4 Donation 5 Other (Specify)	Removal from State	metery, crer	matory or other place	7- 054.9	14	N	· Challan
Ħ	permit. Pa Departmer Importent: any injury		21. Ign ture of Funeral Pervice Licen		757 61 E	. Name and Address	of Facility	100	600 6	T LIGHTON
ä	Depar Impo Impo any ir		Man Visa		2	CONT CORY	Dair F	00522 Hill	Medica	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the death	. Do not ent	er the mode of dying	, such as cardiac or	respiratory arrest,	1	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	0 04 1	atic	Breast	Cane	ov		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ		<u>O</u> , as				9/3
L	LAdillillei		Secuentially list conditions 8.	b						
	ted nsit	Examiner	Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence or):					
	ficate be executed physician and s the burial-transit	Exar	that initiated events resulting in death) Last	c. Due to (or as a consequ	ience of):					
09289	sicia ysicia e bur	edical		d						
_	rtifical ng phy as th		ISSENIA S							
Box	death cert	an/N	23b. was decedent pregnant	23c. If yes, outcome of pregnal 1☐Live birth 2☐Fetal		Ectopic pregnancy			23d. Date of de	,
	the at	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of de 9☐ Unknown	ath 5□	Other (specify)			Month	Day Year
P.0.	law requires that the death certi as been signed by the attending 2 should be detached for use a	Phy	Part II. Other significant conditions of	entributing to death but not resu	Ilting in the w	nderlying cause giver	n in Part I	23e Did tobacco	use contribute t	the cause of death?
Vital Records,	signed I	d by	,	,		igony ing outdoor give.			\ .	robably 4 Unknown
COL	w require been sig should t	Completed						24a. Was an	24h Were a	utopsy findings available
Re	The lav	dmc						autopsy performed?	prior to death?	completion of cause of
ta	icien: Th	a	25. Was case referred to medical				26. Place of Death	1 Yes 25€ N	lo 1 Yes	; 2□ No
\leq	Physicien: this certific ral director,	To B	examiner? 1 □ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatien	Othor		e 5 Residence	6 ☐Other (Spe	ocify)
n of	ding Phy I. After thi funeral		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work?		8d. Describe how inj		,,
Siol	Attending It death. Sctor: Afte	catic	2 Accident investigation		,	M 1 □ Y	es 2 □No			
Division	l or Attendatter death Director:	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		eet, factory, office	2	8f. Location (Street a City or Town, Sta		ural Route Number,
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier	/sician: To the best of my know	vledes das*	a consumed at the start	data and slass -	ad due to the '	a) and ====	atatod
	24 hc 24 hc e Fun etely	edical	(Check only 2 Medical Exam	iner: On the basis of examinat and manper stated.	ion and/or inv	estigation, in my opi	nion, death occurre	d at the time, date ar	nd place, and due	to the cause(s)
	To th within To th comp	Me	29b. Signature and the of certifier			29c. License	number	29d. D	ate signed (Mon	h, Day, Year)
	~ /		> bull the	runty Ms		DI	8587	00	TOBER	n, Day, Year) 2-26, 2004
	18		30. Name and address of person who o	completed cause of death (Item	23a) (Type,	Print)	//			,
	\		toul Gormley	900 Cat	on A	ve Bo	ltimare	mb	2122	5
	Sta Registr		31. Date filed (Month, Day, Year) OCT 2 7 2004	32. Registrar's Signat	ure	low V.				
		- 1	444 ~ 1 EUUT	Year I	- P	MI COUNTY				

DHMH 17 Rev 1/2001

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Registrar

State

lactori 31. Date liled (Month, Day, Year) Dakwood

Ste 100

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2004

Chardon

2 7 28 4S

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie 20 0 4 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October 2029 2004 JOYCE ANN ALDRIDGE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospital Easton Memorial Talbot r 1 Year | If Under 24 Hrs. | 8. Date of Birth | Nonth, Day, Year | JAN 26 1935 7. Age (In yrs. last birthday) 6. Sex 9. Birthplece (State or Foreign 5. Social Security Number Funeral Months 1 M 2 XF TEXAS 69 Director 219-32-3423 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 28e-f ehov treumatic event, the Medical Exardiret must be notified at 1√2Yes 2 ☐ No Director BREVARD MELBOURNE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2771 KENSINGTON DRIVE 32935 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: if item 27 is marked other than "natural", or ita 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: WHITE Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BRADLEY B. RAY LILLIAN M. LINKENFELTER ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: if Item 27 is any injury or other tree oncs. DANIEL T. ALDRIDGE/HUSBAND 2771 KENSINGTON DRIVE, MELBOURNE, FL 32935 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State ^¹ 4 □ Donation 5 □ Other (Specify) FLORIDA MEM. GARDENS | 10-13-2004 ROCKLEDGE, FL 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 21. Signature of Funeral Service Licensee Ostnowshi C.F 71. 200 S. HARRISON ST EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Hospital or Attending Physician: The law requires that the death certificate be executed etastatic that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 ☐ Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Xnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 05 OCTOBER 7 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

LAKSHMI VAIDYANATHAN M.D. 219 S. WASHINGTON ST., EASTON, MD 21601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 11.

			1 - For State Registrer 1. Decedent's Name (First, Middle, La		Co	ertificate of De	ath	Reg		3. Time of Death
F	hysici		ATHENE		ZEVEDO		N.	Month	Day Year 10, 2004	
	Medio/ Examir		4a. Facility Name (If not institution, gir			4b. City, Town, or Local			4c. County of Deal	
			4413 COLFAX S				NGTON		MONTG	
	uneral rector			Sex 7. Ag 1 □ M 2 X F	ge (In yrs. last birthda 76 Yrs.		Juder 24 Hrs. 8. Dours Min. (A	ate of Birth Month, Day, Y	9. Bird Co	thplace (State or Foreign buntry) BRAZIL
yland	MOW		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
в Ма	8a-fs	ctor	MD. MONTGOM	ERY		KENSINGTO	N			YYes 2 □ No
with th	a or 2	Dire	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	
death	ms 23	Funeral Director	4413 COLFAX 11. Marital Status	12. Was Decedent	Ever in U.S. 13	20895 B. Was Decedent of Hispan If Yes, specify Cuban, Me		Yes or No-	U.S.A	
be filed within 72 hours after death with the Maryland lat Hygiene.	item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Modical Exercitive mastice ricitified at		1 Never Married 2 Married	Armed Forces: 1 ☐ Yes 2 X If Yes, Give	No		exican, Puerto Ricar pecify:	n, etc.)	Black, Whit	e, etc.
hours	tural',	ed by	Widowed 4 ☐ Divorced 15. Decedent's E	Year or Dates:	160 Dec		BRAZIL			ITE
in 72	n "na Nedic	Completed	(Specify only highest gi	rade completed)	(Gir	edent's Usual Occupation re kind of work done during . DO NOT use retired)	g most of working	16	b. Kind of Business/	Industry
d with	ar tha	Com	Elementary/Secondary (0-12)	College (1-4or		DMINISTRATIV	E ASS'T.		LAW OFF	1CE
be file	d oth evant	Be (17. Father's Name (First, Middle, Las			18.	Mother's Name (Firs	st, Middle, Ma	iden Sumame)	
should and Men	narke	은	CLEODON 19a. Informant's Name/Relationship		DELHO 105 Ma	ilia Adda (Chantand A	MARI		LOURDES	FERRER
and 2 s	27 is i r traui		WILLIAM G. CART			iling Address (Street and A LARO CT.,				Ip Code)
s 1 all of Hea	item otha		20a. Method of Disposition	· · ·	20b. Place of Dis	position (Name of rematory or other place)	Date		c. Location - City or	Town, State
Page	0 mm = 2		1 Burial 2 Coremation 3 Control of the Core of the Cor			RS CREMATORY	10-12-2	004	RIVERDALE	, MD.
permit. Depart	important: If item 27 is any injury or other tracence.		21. Signature of Funeral Service Light	mbusal	3400001	22. Name and Address of CHAMBERS FUN 5801 CLEVELA	ERAL HOME	& CRE	MATORIUM,	P.A. 20737
174	8		23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that cause one cause on each I	d the death. Do not e	nter the mode of dying, su	ch as cardiac or res	piratory arrest		Approximate Interval Between
	sician		Immediate Cause (Final disease or condition resulting in death)	a. COLON	CANCER					Onset and Death
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ficate	as the	Medical		_ d						
The law requires that the death certificate be executed	igned by the attending be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2X No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	□ Ectopic pregnancy □ Other (specify)			23d. Date of deli Month	ivery Day Year
s that	ned b	by Ph	Part II. Other significant conditions	contributing to death I	out not resulting in the	underlying cause given in	Part I.	23e. Did tobac	co use contribute to	the cause of death?
require	been sig should b	eted						1 🗆 Yes	2 X No 3 □ Pr	obably 4 Unknown
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OI VIICA Physician:	r this certificate iral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Place of Death (Che			
	this al dii	7. To	1 ☐ Yes 2 XNo 27. Manner of Death	28a. Date of Inju	ent 2 ER/Outpati		☐ Nursing Home		e 6 Other (Specinjury occurred	oify)
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the Hospital	To the Funaral Director: A completely filled in by the fu	edical C	29a. Certifier 1 X Certifying P (Check only one) 1 Madicel Exa	hysician: To the best minar: On the basis of and manner st	of examination and/or	ath occurred at the time, da investigation, in my opinion	ate and place, and do n, death occurred at	ue to the caus the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
To th	To th	Me	29b. Signature and title of certilier	1		29c. License nun	nber	29d.	Date signed (Month	n, Day, Year)
	<		· Gol C			DC 19	655		OCT. 11,	2004
	-		30. Name and address of person who				n w **	UACUTY	MOTON TO	0 20007
	. Sta	ate	JOHN L. MA 31. Date filed (Month, Day, Year)		rar's Signature	RESERVOIR R	υ., Ν.W.,	WASHII	NGTUN, D.	J. 20007
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	ъ		1. Decedent's Name (First, Middle, La	ist)						- 2	2. Date of D	eath			3. Time of Death	_
	Physici: /Medic		Donna Marie An	adio							Octob	per 7	200	oar 04	10:00 P M	A
	Examin		4a. Facility Name (If not institution, git		nber)		4b. City	, Town, or I	Location o	f Death		4c.	County of [
1			233 Nottingham H	i11			Sh	erwoo	d For	rest		A	nne A	rund	el	
	Funeral		5. Social Security Number 6.	Sex	7. Age (In yrs.		If Unde	r 1 Year Days	If Under 2 Hours	24 Hrs. 8	B. Date of B (Month, E	irth Day, Year)	9.	Birthpla	ce (State or Foreign	n
	Director		219 42 /112	1□ M 2. F	60) Yrs.									ĺand	
	pu ≱	-	Usual Residence of Decedent 10a. State 10b. County		10c Ci	ty, Town or Lo	oation							100	1. Inside City Limits	_
	aryla shov	-	Toa. State		100.01	iy, rown or Le	Cation							100	1 ☐ Yes 2 ∰No	
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\geq	mark matt	P	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	na Addres	s (Street au					r Town, Sta	te. Zip C	ode)	_
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			shock, or heart failure. List only Immediate Cause (Final	one cause on ea	ach line.) [nterval Between Onset and Death	
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Ö	> Q 5	Completed							,		24a. Wa	c an	24h Wer	a autons	y findings available	
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Division of	Attending or death.	Certification:	3 Suicide 6 Could not l	De 300 Blaco	of Injury - At h	nome, larm, str					II. Location	(Street an	d Number o	r Rural F	Route Number,	
<u>></u>	or A after Direct in b)	ertif	4 Homicide determined	buildir	ng, etc. (Speci	fy)	501, 14010	ry, onlo			City or To	wn, State)	, , , , , , , , , , , , , , , , , , , ,	routo rrainizor,	
_	To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the		29a, Certifier 1 Certifying P	hysicien: To the	best of my kn	owledge deat	h occurre	d at the time	a, date and	d place an	d due to the	cause(e)	and manne	r as stat	ed.	-
	24 h 24 h Fur etely	Medical	(Check only 2 Medical Exe	miner: On the ba	isis of examina	ation and/or in	vestigatio	n, in my opi	inion, deat	th occurred	d at the time	, date and	place, and	due to th	ne cause(s)	
	To the within 2 To the comple	Me	29b. Signature and tyle of certifier	~ 0			25	c. License	number			29d. Dat	e signed (M	lonth, Da	y, Year)	-
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			7.7	J,	a of death ():-	- 02a) /T::	Drint)		10.	70 0		10	101		- 1	
			30 Name and address of person who	S6(ON(or death (Ite	1) G	00	Re	stya-	te R	d. 1	Ann	apoli	S,	Uld,	
		to	31. Date filed (Month, Day, Year)	3 R	egistrar's Sign		20)	1 '	- 4	7				-
	Sta Registr		OCT 1 2 2	004	Ger a	M An	and I	£								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) **Physician** 14, Roy Douglas BEAN 1:09 p.m. 2004 October /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Fecility Name (If not institution, give street and number) Examiner Washington 15714 Wishard Road Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** 1∭ M 2□ F Yrs. 57 May 30, 1947 Maryland Director 212-50-8687 Usuel Residence of Decedent s 1 and 2 should be filed within 72 hours after death with tha Marylend if Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinal must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. Stete 10b. County 1 ☐ Yes 2 🖾 No Director Hagerstown Maryland Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 21740 15714 Wishard Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S Armed Forces? 11 Marital Status 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0020 white 2 3 ☐ Widowed 4 X Divorced Yeer or Dates Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Elementary/Secondary (0-12) Metal fabrication painter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) parmit. Peges 1 end 2 should be file Depertment of Health end Mental Hy Important: if Item 27 is marked oth any Injury or other traumatic event Susan Kretzer Eston Leroy Bean 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P. O. Box 891, Funkstown, Md. 21734 Jackie Fisher - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/18/04 Hagerstown, Maryland Cedar Lawn Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature J. Frieral Service Licensee MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Maryland 21740 23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tnterval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical ACUTE MYOCARDIAL INFARCTION Few min Examine Due to (or as a consequence of) Examiner 1-270 CARDIOMYOPATHY sician and bunal-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): ettending physician for use es the burial Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jonknown þ 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed After this certificata has 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes 2 No To the Hospital or Attending Physi within 24 hours efter death.
To the Funerei Director: After this completaly filled in by the funeral dir 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Deeth 28a. Date of tnjury (Month, Day Year) Certification: 1 Natural 5 ☐ Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 1[4-certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 29a. Certifier Medical | Larger all ying | First product. To the best of the same deed of actine time, date end place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier D18019 OCTOBER 15, 2004 - Com Desper 2 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) Dr. V. Datta, 340 Mill Street, Hagerstown, Maryland 21740 Registrar's Signature 31. Date filed (Mont

DHMH 16 Rev 6/95

State

Registrar

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	/Media	al	Beulah P. Brooks	3					UC	tober	6, 20	04	3:10	Рм
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or I	Location of Dea	ath		4c. County	of Death		
			Holy Cross Hospit	tal		Silv	ver S	pring			Mont	gomer	·v	
	Funeral		5. Spriat Security Number 6. Se	7. Age (//	n yrs. last birth	day) If Under	1 Year	If Under 24 Hi	rs. 8. Da	te of Birth	,1927	9 Birtho	lace (State or	Foreign
	Director		246-36-3646 246-36-5644]М 2[X F	77 Y	rs. Months	Days	Hours Mi	n. (Mo	onth, Day, Y	1927	Nort	R Caro	1ina
			Usual Residence of Decedent						рер		, + , ~ ,			
	and		10a. State 10b. County	10	Oc. City, Town	or Location						1	0d. Inside City	✓ Limits
	sho	ō	Maryland Prince Ge		Bowie								1X Yes ∶	
	89-1	ct		sorges	DOMTE									
	ih th)ire	10e. Street and Number			10f. Zip	Code			100	g. Citizen of \	What Coun	try?	
	23a	ai	3702 Excalibur Co	ourt unit l	02	20	0716				Unite	d Sta	tes	
	dea E	Jer	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Deced	dent of His	panic Origin?	(Specify Ye	s or No-		e - Americ		
G	or Ite	T	1 ☐ Never Married 2 Married	1 ∐Yes 2 🕅 No					eno Hican,	etc.)		ck, White,		
ğ	urs a	by Funeral Director	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2KI No	Specify:			Specif	y: Bla	.ck	
Ŏ	s ho	Completed	15. Decedent's Edi	ucation	16a. I	Decedent's Usua	al Occupat	tion		16	6b. Kind of B	usiness/Inc	fustry	
15	n 7	ojet	(Specify only highest grad	de completed)		(Give kind of wo life. DO NOT u	rk done du se retired)	uring most of w	rorking				1000,	
12	with thau	Ĕ	Elementary/Secondary (0-12)	College (1-4or 5+)		Computer					Dept.	of Da	fanca	
2	lled lygir ther nt, 1		17. Father's Name (First, Middle, Last)			Joinpuce.		18. Mother's N	ame /First				Tense	
Ĕ	be f d old old old old old old old old old ol	Be									noen Suman	10)		
X	Mer Mer arke	T _o	Ernest C. Person					Mary A						
Maryland 21215-0036	and and ls m		19a. Informant's Name/Relationship (T	ype, Print)	19b.	Mailing Address	(Street ar	nd Number or I	Rural Route	Number, (City or Town,	State, Zip	Code)	
≥	alth alth 127 Br tr		Robert C. Brooks	(husband) 370	02 Excal	libur	Court	#102	Bowi	le, MD	207	16	
9	S 1 & f He f He lter		20a. Method of Disposition			Disposition (Nar			Date		c. Location -		wn, State	
20	age and o		1 ∑8urial 2 ☐ Cremation 3 ☐ I `4 ☐ Donation 5 ☐ Other (Specify)	Heritoval Ironi State		ny Memon			112/0) / T		V	T	
⋣	nita nita		21. Signature of Funeral Service Licens		патшо				0/12/0		Landov			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23e or 28e-1 show any Injury or other treumatic event, It a Madical Examinar must be notified at once.			10.00	/			of Facility Mo						
	10100		vende I	ong son				ia Ave.				on, D		0012
н			23a. Part1. Enter the disease, or comp shock, or heart failure. List only or	lications that caused the one cause on each line.	e death. Do n	ot enter the mod	le of dying,	, such as cardi	ac or respi	ratory arres	t,		Approximate Interval Between	een
	Physician		Immediate Cause (Final disease or condition	Pnuemo	nia								Onset and De	eath
	/Medical		resulting in death)	Due to (or as a co		f):							weeks	
	Examiner					eart Fai	lure						years	
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	nsit	Examiner	Cause (Disease or injury	Corona	ry Arta	ery Dise	2250							
	xect and al-tra	xal	that initiated events resulting in death) Last	Due to (or as a co			asc						years	
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68760,	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	hysician/Medicai		d										
9	entiffi ling I e as	Me	IF FEMALE:							-				
Вох	th c	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐	pregnancy ∃Fetal death	3 □Ectopic pr	regnancy					te of delive	-	
	ne dea the at hed fo	sici	1 ☐ Yes 2 ☐ No	4□Pregnant at tim 9□Unknown	e of death	5 Other (sp	oecify)				Mo	onth	Day Ye	ear
P.O.	by the		9 Unknown	301010411										
	s tha	ру Р	Part II. Other significant conditions co	ntributing to death but n	ot resulting in	the underlying o	ause giver	n in Part I.	23	e. Did toba	cco use cont	ribute to th	e cause of de	ath?
p	uirei Isig Id ba	d D	Lung Cancer							1 🗆 Yes	2 🗆 No	3 Probi	ably 4X Un	nknown
Ö	w requires that s been signed to should be deta	Completed	Control	D1 - 12 -						. 106	0.45		P. 47-	
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ita	iclan: The certificate rector, pag	Be	25. Was case referred to medical examiner?					26. Place of D	eath (Chec	k only one)				
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0	g Ph er th		27. Manner of Death	28a. Date of Injury (Month, Day Ye	28b. Ti	me of 2 jury	8c. Injury				injury occur			
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<u>/is</u>	Attendir death.	Ę	3 ☐ Suicide 6 ☐ Could not be	200. Flace of Injury	- At home, fan	m, street, factory	, office					er or Rural	l Route Numbe	er,
ō	of efte Oire	Certification:	4 Homicide	building, etc. (Specify)				Cit	y or Town, :	State)			
	spita ours seral filled		29a. Certifier 1 Certifying Phy	ysicien: To the best of n	ny knowledae	death occurred	at the time	date and place	ce and due	a to the cau	co(c) and ma	nnor ac ch	ntod	
	Hos Pun Fun	lica	(Check only 2 Medicel Exem	iner: On the basis of ex and manner stated	amination and	or investigation	, in my opi	nion, death oc	curred at th	e time, date	e and place,	and due to	the cause(s)	
	To the Hospital or Attending within 24 hours effer death. To the Funeral Director: After completely filled in by the funer	Medicai	29b. Signature and title of certifier	and marinor stated		290	c. License	number		29d	I. Date signed	d (Month I	Ogy Year)	
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	Y		JAWama D	yrnojor i	(V)		D516	70			Octob	er 9,	2004	
			30. Name and address of person who c			,								
_			Towana Spriggs,	M.D. 1400	0 Sprin	ng Stree	t, S	ilver S	pring	, MD	20910)		
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	4 1.	-1	A						
		1.3	1 11 2 1 2 2 2 1 1	4 1 7 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	/	2 (16)	TOO W.A.	e.						

The law requires that the death certificate be executed as the burial-transi and the attending physician Division of Vital Records, P.O. Box 68760 use peeu page 2 certificate After or Attending after death the filled in by

/Medical Examiner within 24 hours a

Physician

/Medical

Examiner

Director

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Completed

Be

Funeral

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants: If Item 27 is marked other then "neturel", or Items 23a or 28a-f show any injury or other freumatic event, the Modral Examiner must be notified at ours. S

Physician

Examiner by Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed Be 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Certification; To 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 | Homicide Medicai 29a. Certifier (Check only one) 29b. Starting and title of certifier A. Nawar D50987 10-8-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HIMED NAWAZ POBOX 83819 Cailhers burg mo 20883. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001 ORIGINAL

State of Maryland / Department of Health and Mental Hygien 2001, 34120 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year 200 /Medical or Location of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town. 4c. County of Death Examiner **Funeral** Security Number last hi Birthplace (State or Foreign Country) Days 1 X M 2 □ F 71 Yrs 577-42-5890 Director D.C Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner dust be notified at Washington Director Yes 2 No D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or iteme 23e 20001 461 H Street, N.W. by Funeral U.S. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 MNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black If Yes, Give Year or Dates: 3 ♥Widowed 4 Divorced "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Retail Security Officer 12 marked other permit. Pages 1 and 2 should be file Department of Heath and Mental Hy, Important: If item 27 is marked othe eny injury or other traumatic event, 9068. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဂ္ Charles Edward Brown Lorraine Marie Garner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Vanessa B. Allen-Daughter 1211 Palmer Rd. #3, Ft. Washington, MD 20744 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Bunal 2 ☐ Cremation 3 ☐ Removal from State Lincoln Cemetery 10-18-04 Suitland, MD * 4 Donation 5 Other (Specify) 22. Name and Address of Facility Bonnette & Assoc. Funeral Home 21. Signature of Funeral Service Licensee 2504 28th St., N.E., WDC 20018 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical **Examiner** 31212 Lunca Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? ģ 90 4 Unknown Completed 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No : After this certifical funeral director, p 25. Was case referred to medical examiner?

Yes 2 □ No Certification: To Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2DER/Outpatient 3□ DOA 27. Manner of Death

1 Natural

2 Accident 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No completely filled in by the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours after To the Funeral Dire 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) jend mis Physizan who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Sig State Registrar

		1	For State Registrar	State of Ma	aryland / De	epartme Certifica	nt of H te of L	ealth and N Death		Reg. No.	004	341	22
	ာ		Decedent's Name (First, Middle,	Last)					2. Date of De	ath Day	Year	3. Time of	
	Physicia /Medic		Edward L.	Browning					October	12	2004	4:55	P ^M
	Examin		4a. Facility Name (If not institution,	give street and number)		4b. City		Location of Death			County of Death		
			204 Plainview A			If I lood		t Airy	0.0 (0)		Frederi		F
	Funeral Director		218-38-3869	450 M OFF	e (In yrs. last birtho	Months		Hours Min.	8. Date of Bin (Month, Date July 3	0, 19	9. Birth Con Mar	place (State of intry) yland	r Foreign
	ryland show		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	or Location						10d. Inside Cil	•
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	s 23e	ia.	204 Plainview	Avenue 12. Was Decedent	Ever in U.S.	13 Was Dec	2177		ecify Yes or No		ted Sta 4. Race - Amer		
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic avant, I're Mydical Eraini at must be notified at once.	by Fur	11. Marital Status 1 □ Never Married 2 ☑ Marrie 3 □ Widowed 4 □ Divorced	Armed Forces?			ecify Cuba 2⊠ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	Rićan, etc.)		Black, White Specify: W	hite	
21215-0036	in 72 ho n "natur Nedice	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or	(ecedent's Us Give kind of v ife. DO NOT	ual Occupa vork done d use retired	ation during most of work)	king	16b. Kin	nd of Business/I	ndustry	
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	e file al Hyg othe vant,	BeC	17. Father's Name (First, Middle, La	ast)				18. Mother's Nam	ne (First, Middle	, Maiden S	Sumame)		
/lai	should be f and Mental I s marked or umatic ava	To E	Lindsay Lightf	oot Brownin				Mary Vi					
Maryland	2 sho and Is me	1 3	19a. Informant's Name/Relationshi	_				and Number or Ru					
	and lealth m 27 har tr		Jane A. Brownin	g / Wife				w Avenue	Mt. Ai		MaryLan cation - City or		-
Baltimore,	Pages 1 nent of H ant: If ita ury or ot	1 18	20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 4 ☐ Donation 5 ☐ Other (Sp.		20b. Place of Cometery, Frederi	ck Cre	mator	y 2	ber 14, 004	Fred	lerick,	Maryla	
Balt	permit. Departi Import any inj		21. Signal are of Fur eral Service L	It		8 E.	Ridge	ss of Facility St ville Blv	d. Mt.	Air			
			23a. Part1. Enter the diseate, of c shock, or heart failure. List of Immediate Cause (Final	complications that cause nly one cause on each I	d the death. Do no	/			or respiratory a	arrest,		Approximat Interval Bet Onset and I	ween Death
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	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence of):							
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Box	death certif e attending id for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death	3 □Ectopid 5 □ Other				2	3d. Date of deli Month	,	Year
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Vital Records,	e ~ e	Completed							perf	opsy formed?	prior to death?	topsy findings completion of c	available ause of
a			25 Mag anna referred to modical					26. Place of Dea		2 No	1 Ll Yes	2 □ No	
Σ		o Be	25. Was case referred to medical examiner? 1 Yes 2	Hospital:	ent 2 ER/Out	natient 3	DOA Oth	00	.0942.032.2		3 □Other (Spec	cify)	
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Division	r Attan ter deat iractor: I by the	Certification;	2 Accident Investig 3 Suicide 6 Could r 4 Homicide determi	ot be 28e. Place of Ir	ijury - At home, fari tc. <i>(Specify)</i>	m, street, fac	ory, office			(Street and own, State)	d Number or Ru)	rai Route Num	nber,
	To tha Hospital or within 24 hours af To the Funaral D completely filled in	edical C	29a. Certifier 1 Certifyin (Check only 2 Medical I	g Physician: To the bes Examiner: On the basis and manner s	of examination and	death occurr /or investigat	ed at the tir ion, in my d	me, date and place ppinion, death occu	, and due to the irred at the time	e cause(s) , date and	and manner as place, and due	stated. to the cause(s	5)
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•	12		30. Name and ddr. s of the Mantin Ede I				not.	Raltima					
			Martin Edel 31. Date filed (Month, Day, Year)		22 Green trar's Signature	ie otr	set	Baltimor	E PID 2	.1201			
	Regis	ate trar		4 2004 6	eneva	5	Spo	uls:					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Charles W. Bangert, Jr. 8, Oct. 6:43 a M 2004 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jan. 13, 1952 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**⊠**M 2□ F 217-62-8750 Director 52 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location Item 27 is marked other then "neturel", or Items 23a or 28a-f show other traumatic event, the Mcdical Examiner must be notified at 10d. Inside City Limits MD Anne Arundel Severna Park Director 1 Yes 21 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 106 Cove View Trail 21146 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 72 h and Mental Hygiene. 7 Is marked other then "no Maryland Environmental Elementary/Secondary (0-12) College (1-4or 5+) Budget Director +5 Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ss 1 and 2 should be fill of Health and Mental Hillem 27 Is marked oth Charles W. Bangert, Sr. Bettie Kaiser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Bangert/Wife 106 Cove View Trail, Severna Park, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Oct. 11, 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If Ite any Injury or ot 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Baltimore, MD Metro Crematory * 4 ☐ Donation 5 ☐ Other (Specify) 2004 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 21. Signature of Funeral Service Licensee 233 Part Enter disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or flear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final stock? **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Box 68760 Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown been signed by should be detact Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? res 2 No certificate 1 Yes 2 No 1 Yes the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 은 1 Yes 2 ER/Outpatient 3 DOA 1 🗌 Inpatient this After this funeral d 28a. Date of Injury (Month, Day Year) 27. Manney of Death 28b Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending unerel Director: Aft investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funerel D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 28686 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO nistrar's Signature 31. Date filed (Month Registrar

hysicia	an	Decedent's Name (First, Middle, T.T.T. CHAN	Last)						Date of Deat Month	Day	-	a. Tir	ne of Deat
/Medic		LIV CHAN 4a. Facility Name (If not institution,	give street and num	nber)		4b. City, Town, o	or Location of		0	0 9 4c. 0	200 County of I	2 - 1	97
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neral			6. Sex 1 ☐ M 2 🕱 F	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 2 Hours	Min. (Date of Birth Month, Day,	Year)	9.	Birthplace (Si Country)	ate or For
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MOM III		10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Insi	de City Li
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Important: If item 27 is marked other than "natural", or fields 23s or 28s-1 show any Injury or other traumatic event, it a Modical Examinat must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	Armed For	rces? 2 X No e		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ※ No		Puerto Rica	n, etc.)		Black, \	American India White, etc. ASIAN	i(1,
ileal E		15. Decedent's (Specify only highest				dent's Usual Occup		of warding		16b. Kin	d of Busin	iess/Industry	
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or oth		20a. Method of Disposition 1 □ Burial 2 ▼ Cremation 3		State <i>cer</i>	metery, cren	sition (Name of matory or other pla	. 1	Date				y or Town, Sta	te
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			For State Registrar	State of Marylar	nd / Depa <i>Cei</i>	artment of H tificate of L	ealth and M Death		en2004	34125
			1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Mary Elizabeth	Corvin				Octoobe		4 5:15 AM
	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Death		4c. County of Dea	th
			Beverly Health			Hagers			Washingto	on County
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	V	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	rear) Co	thplace (State or Foreign ountry)
	Director	-	Usual Residence of Decedent	6	3 113.			August 3	, 1941Wasl	nington DC.
	and	}	10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	Manyl f sho	0		_						1∭Yes 2□No
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	Sa or		472 ** 11			2540	1		II C A	
	has 2:	era	473 Nathaniel Driv	Was Decedent Ever in U	J.S. 13.1	Was Decedent of Hi f Yes, specify Cuba		ecify Yes or No-	14. Race - Ame	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic svant, the Musical Exaction must be notified at	by Funeral	1 ☐ Never Married 2 🔀 Marned 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates:		Yes, specify Cuba I□Yes 2☐No	n, Mexican, Puerto Specify:	Hican, etc.)	Black, White Specify: Wh	nite
ğ	2 hou	ed	15. Decedent's Educ	cation	16a. Deced	lent's Usual Occupa	ation	. 1	6b. Kind of Business	/Industry
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7	filed withi Hygiene. other than	E O	Elomonia, y Cookings, y (o 12)	2	I F	Iomemaker	·- <u>-</u>		Personal	Residence
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lar	Mental Mental arkad o	ToE	David Neal				Virginia	-ColdTro	1	
Maryland 21215-0036	2 should and Men is marks	3 3	19a. Informant's Name/Relationship (Ty)	oe, Print)			and Number or Rura	al Route Number,	City or Town, State,	Zip Code) 25401
	and 2 saith n 27 i		William Buford Cor		_				sburg, W.	Virginia
ore	of He of He roth		20a. Method of Disposition 1 ☐ Burial 2 MCremation 3 ☐R		Place of Dispo cemetery, crer	sition (Name of natory or other plac	e) [Date 2	Oc. Location - City or	Town, State
Ĕ	Page nent ant: If		'4 □ Donation 5 □ Other (Specify)		mithsbu	ırg Cremat	ory Oct	15, 04	Smithsburc	Maryland
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra 20028.		21. Signature 7 Fun ral Service License		22	. Name and Address	s of Facility Do	uglas A.	Fiery Fur	neral Home
m	82558	. 11	- Lanuel	I Taully)/ · 1	331 Easte				yland 21742
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the dea	ith. Do not ent	er the mode of dying	g, such as cardiac	or respiratory arres	st,	Approximate Interval Between
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15	/Medical		resulting in death)	Due to (or as a conse			0(101			21107111
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Вох	death certific e attending p id for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet	al death 3[Ectopic pregnancy			23d. Date of de Month	livery Day Year
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ec	aw Is b	ple						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
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Division of Vital R	or Attendated death Director:	Certification;	4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, str ify)	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 X Certifying Phys	sician: To the best of my kn	owledge do-4	occurred at the time	ne date and size	and due to the co-	(ep/e) and marror -	e etated
	Hos 24 ho Fun Fun	edical	(Check only 2 Medical Examin	ner: On the basis of examin and manner stated.	ation and/or in	vestigation, in my of	pinion, death occuri	red at the time, dat	e and place, and du	s stated. e to the cause(s)
	To the within 2. To the Complet	Mec	29b. Signature and title of certifier	and the state of		29c. License	number	29	d. Date signed (Moni	th, Day, Year)
	F ≥ F 8		May son &	Such.		12	8360		-	
	4		30. Name and address of person who co	impleted cause of death //s-	um 23a) /T.m-	Print)	- 10 IV		(3 - 1 7	
1.)	1,		150. Name and address of person who co	Show.	26.8 /	mill. &	t-vest- 1	400gpvs1	10-14 Veru 17	121742
1)	Sta	to	31. Date filed (Month Pey Year)	32. Registrar's Sign	nature	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, 1	1.91		
	Regist		001 18 20	004	4	1				

State of Maryland / Department of Health and Mental Hygien 001 1 - For State Registrar 34126 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** LaVerne Oakley October 8, 200^{Ygar} Cinciotta 11:58 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 3501 Twin Branches Court Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 6. Sex 8. Date of Birth (Month, Day, Year) April I, 1920 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Onio 84 Yrs. Director 579-14-3031 Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 23a or 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at Directo 1 ☐ Yes 2 X No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3501 Twin Branches Court 20906 USA Funeral or Itams 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) othar than Elementary/Secondary (0-12) College (1-4or 5+) filed with Hygiene. 12 Secretary Medical njury oc othar traumatic evant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked o James F. Oakley Angela McCaffrey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nicholas Cinciotta/ Husband 3501 Twin Branches Court, Silver Spring, MD 20906 20b. Place of Disposition (Name of cometery, crematory or other place)
Gate of Heaven
Cemetery 20a. Method of Disposition October 12, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 □Donation 5 🖾 Other (Specify) Entombment 2004 Silver Spring, Maryland 21. Signature of Juneral Service Licens Francis J. Collins Funeral Home Inc. 500 University blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Arteriosclerotic Cardiovascular Disease resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certiticate be executed the attending physician and the to use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ a 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown should Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has certificate 1 ☐ Yes 2 X No tha Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5% Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient P 1 ☐ Yes 2 🖾 No 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification; 28d. Describe how injury occurred Atter 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a To the Funeral I 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 D08381 October 11, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Benjamin Avrunin, M.D. 18111 Prince Philip Drive, Olney, MD 20832

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

12

Darks

32. Registrar's Signature

		1	For State of Ma	aryland / Depa <i>Cer</i>	artment of He tificate of L	ealth and Me Death	ental Hygie Reg.	2004	34127
	Physicia		Decedent's Name (First, Middle, Last) Sarah	CHEVELI	ER		2. Date of Death Month October	Pay, 2004	3. Time of Death 6:15 A M
	/Medic Examin	_	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of Death	1
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	Funeral Director		1 ☐ M 2 💢 F	e (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	B. Date of Birth (Month, Day, Ye	ar) Coi	nplace (State or Foreign untry) York
			058-07-3478 Usual Residence of Decedent			D	20,	I JII NEW	
	ahow	_	10a. State 10b. County	10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☒ No
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lary	and N is mail		19a. Informant's Name/Relationship (Type, Print)		•	and Number or Rural			
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Baltimore,	permit. Pages 1 Department of H Importent: If ite any injury or or		1 Burial 2 □ Cremation 3 □ Removal from State	cemetery, crer	natory or other place				
Ħ	artme		* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun (1) Service Licensee	22	Cemetery Name and Addres	s of Facility		iami, FL	
Ba	Dep Imp any				•	Hebrew Fu			20012
			23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each li	d the death. Do not entine.	er the mode of dying	g, such as cardiac or	respiratory arrest,	con, be	Approximate Interval Between
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ita		BeC	25. Was case referred to medical examiner?			26. Place of Death			
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)	4		Howard / Juld	Chy.		20388	00	ctober 12	, 2004
			30. Name and address of person who completed cause of Howard S. Goldstein, M.D.			1 #105 p	ockv111a	. MD 208	52
	Str	ate	31. Date filed (Month, Day, Year) 32. Regist	rar's Signature	A		OCKVITTE	, FID 200	<i>J</i>
	Regist		OCT 13 2004	va B	sports				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 4 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 9:30 AM 7, October 2004 Salley Ann Cohen /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Months 1 □ M 2 🖺 F 79 VA 227-20-3972 10/09/1924 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10h County in than "naturel", or items 23a or 28a-f show the Medical Example must be notified at 1. Yes 2 □ No MD Director Anne Arundel Annapolis 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 701 Glenwood Street, #412 21401 USA Be Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ੴ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Bookkeeper Hote1 ulth and Mental Hygie 27 is marked other in treumatic event. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fil ment of Health and Mental H ent: If item 27 is marked otl Richard Wessell ဥ Amanda Harrison Wessells 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ed Weatherman/Son 1812 Oak Bowery Dr., Opelika, AL other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 0 Alexandria, VA Metropolitan 10/9/04 21. Signature of Funeral Service License 22. Name and Address of Facility Advent Funeral Services 7211 Lee Highway, Fails Church, VA or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only the cause on each line. 23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due/to (or as a consequen Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse Examiner transit death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial-P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown n signed by ti 23e. Did tobacco use contribute to the cause of death; Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 110 2 No 1 Yes certificate or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 No 2 ER/Outpatient 3 DOA 2 1 🗌 Yes this 27. Manner of Death 1 Natural 28d. Describe how injury occurred Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A 2 Accident the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature D53111 MIT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 Medical Parkway, Annapolis, 31. Date filed (Month, Day, Year) 32. R strar's Signature State

DHMH 17 Rev 1/200

Registrar

State of Maryland / Department of Health and Mental Hygien 2004 1 - For State Registrar Certificate of Death 2. Date of Death L Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** a Jober 200 June Juanita DEBIASE 0831 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Aug. 17,1924 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🖾 F 80 Director 219-12-0774 Pennsylvania Usual Residence of Deceden the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Item 27 is marked other than "naturel", or items 23e or 28e-f show other treumatic event, the Madical Examiner must be notified at 1 XYes 2 No Director Hagerstown Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 21742 USA 49 Sunbrook Lane death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Amed Forces? 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. em 27 Is marked other than "naturel", or iter 1 Never Married 2 Married 1 ☐ Yes 2 TNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: Specify: white à 3 X Widowed 4 ☐ Divorced ed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Complet Elementary/Secondary (0-12) College (1-4or 5+) homemaker her own home 0 8 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be Franklin Stains Gladys Pearl unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 201 N. Cleveland Ave., Hagerstown, Md. 21740 it of Health Philomena DeBiase - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of Hi
Importent: If Iter
any injury or oth 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rose Hill Cemetery 10/19/04 Hagerstown, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature de l'eral Service License 22 Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 100MONIA /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit certificate be executed Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the use as I IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No
9 Unknown jo 4□Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 2 No 1 Yes 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Appatient No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury 28c. Injury at Work? 27. Magner of Death 28b. Time of 28d. Describe how injury occurred e Hospitel or Attending Pl 24 hours after death. e Funerel Director: After tl After Certification: Natural (Month, Day Year) 5 Pending investigation 1 TYes 2 🗌 No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 78 1110 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15A Honth, Day, Year) 11110 medicAl 32. Registrar's Signature State OCT 18 2004 Registrar

		For State Registrar		State of	iviai yiai i		irtment of F tificate of i			eg. New O. O. I	
			e (First, Middle, Las	t)					2. Date of Deat	h 2001	THE OF DEATH
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/Medic Examin		4a. Facility Name (i	If not institution, give	street and numb	per)			r Location of Death		4c. County of D	Death
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Funeral		5. Social Security N	lumber 6. Se	9x 7.	Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9.	Birthplace (State or Foreign Country)
Director		218-24-38	876	Š M 2□F	74	Yrs.	Worth's Days	Tiodis iviii.	Mar 8,	1930	MD
p		Usual Residence o			10a Cit	y, Town or Lo					10d Inside City Limits
show	_	10a. State	10b. County								10d. Inside City Limits 1 Yes 2 No
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or 2	Dir.	10e. Street and Nu					10f, Zip Code		1	0g. Citizen of Wha	t Country?
ath w 238	ra	306 Purne	ell Street				21863			U.S.	
tems	Funeral Director	11. Marital Status		12. Was Decede Armed Forc	es?	.S. 13. \	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (S _l an, Mexican, Puert	pecify Yes or No- o Rican, etc.)		American Indian, White, etc.
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man man	Ē	19a, Informant's N	lame/Relationship (Type, Print)		19b. Mailir	g Address (Street	and Number or Ru	ral Route Number	City or Town, Sta	ite, Zip Code)
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Heal Heal ter		20a. Method of Dis		<u>.</u>	20b. F	Place of Dispo	sition (Name of			20c. Location - City	y or Town, State
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of H-alth and Nental Hygiene. Importent: If item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Mucical Examiner must be notified at Once.			☐ Cremation 3 ☐ 5 ☐ Other (Specify		ate		natory`or other plac O UMC Cen		6/2004	Snow HIll	I MD
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	-	23a Parti Enter	The #fease, ir compart failure. Tist only	olications that cau	used the deat	h. Do not ent	518 West er the mode of dvir	Rd., Sal	isbury I	MD 21801	Approximate
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sicien: The la certificate ha irector, page 2	Be	25. Was case refe examiner?		Hospital:			Ott	or	ath (Check only on		
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death death tor: the	ical	2 Accident 3 Suicide	investigation 6 Could not b		of Injury - At h	ome farm str	eet, factory, office		28f. Location (St	reet and Number of	or Rural Route Number,
or A after Direction by	Certification;	4 Homicide	determined		g, etc. (Specia		eot, ractory, omoc		City or Town	i, State)	, , , , , , , , , , , , , , , , , , , ,
To the Hospital or Attanding Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	S	29a. Certifier	1 Cartifying Di	vsician: To the h	nest of my kny	Owledge death	occurred at the til	me date and place	and due to the or	ause(s) and manne	ar as stated
Hos Pun Fun	edical	(Check only one)			sis of examina						due to the cause(s)
To the within 2 To the complet	Med	29b. Signature an	d title of certifier	and maille	stated.		29c. Licens	se number	2	9d. Date signed (A	Month, Day, Year)
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		1	dress of person who	completed cause	or death (Iter	m 23a) (Туре,	Print)	11 51	<11.18h	us n	20
		31. Date filed (Mo	1	32 Ra	gistrar's Signa	ature 1	1	1	20,000	7 111	
St Regist	ate		OCT 1 4 20		merce	B	ppour				

Division of Vital Records, P.O. Box 68760,

James Dickney 218-24-3876
Baltimore, Maryland 21215-0036

Registrar DHMH 17 Rev 1/2001 OCT 1 4 2004

			For State Registrar	State of M	Maryland	d / Depa	artment of H rtificate of	Health ar <i>Death</i>	nd Mental Hy	Reg. No.	004		
	Physici	an	1. Decedent's Name (First, Middle, L		<u>.</u>				2. Date of Do	Day	Year	3. Time of	
	/Medic	al	Gloria V.	Dav			4b. City, Town, o	or Logation of	Octobe		2004 County of Deat	9:00	P M
	Examin	ięr'	4a. Facility Name (If not institution, garantee Court Independence Indepe			1e	Hyattsv		Death		ince Ge		
	Funeral	4 ;			Age (In yrs. I		If Under 1 Year	If Under 24	4 Hrs. 8. Date of Bi	rth	9 Rint	hplace (State ountry)	or Foreign
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	D .		Usual Residence of Decedent		10a Cib	, Town or Lo	antion					10d. Inside C	itu Limite
	anyla shov	Ä	MD Prince G	enrae!s		11ege							2 □ No
	28a-1	ecto	10e. Street and Number			TICEC	10f. Zip Code			10g. Citiz	en of What Co	1	
	with is or i	اق	5207 Palco Plac	e			20740)		-	ed Stat		
	72 hours after death with the Maryland natural', or Itams 23s or 28s-f show Jisse Essa i frefrout te notified at	Funeral Director	11. Marital Status	12. Was Decede	nt Ever in U.	S. 13.			n? (Specify Yes or N Puerto Rican, etc.)		4. Race - Ame	rican Indian,	
မွှ	or itan	Fur	1 Never Married 2 Married	Armed Force			If Yes, specify Cub 1 ☐ Yes 2X No		Puerto Hican, etc.)		Black, White Specify: Cau		
03	rat', c	d by	3 Widowed 4 Divorced	If Yes, Give Year or Date	s:		10 105 200 140	Зреспу.			Specify: Gau	Casian	
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altimore,	of Hear fitam rotha		20a. Method of Disposition XXBurial 2 ☐ Cremation 3	Removal from Sta	20b. P	lace of Dispo emetery, cre	osition (Name of matory or other pla	ice)	Date	20c. Loc	cation - City or	Town, State	
Ĕ	Pages ment of I		*4 □ Donation 5 □ Other (Spec	eify)	Ft.				/14/2004	Brent	wood,	MD	
Ball	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Lie	mmb _1			2. Name and Address Lines Blad		neral Home g Road Br	entwo	ood, MD	20722	
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that causy one cause on each	sed the death h line.	n. Do not en	ter the mode of dyi	ing, such as c	ardiac or respiratory	arrest,		Approximate Interval Bet Onset and	tween
	Pnysician	0	Immediate Cause (Final disease or condition	_a_ Ishem:	ic car	diomyp	athy					Oliser and	Death
	/Medical Examiner		resulting in death)		as a consequ ic Ren		1						
	ite Mad	Į.	Sequentially list conditions,	b									
	rted Insit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Atral	as a consegu fibri	llatio	n						
Ć	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Exa	that initiated events resulting in death) Last	Due to (or	as a consequ	uence of):	cardia						
8760,	te be ysicia ne bur	icai		d									
9	ntifica ng ph s as th	Med	IF FEMALE:										
Вох	ath ce ttendi or use	an/I	23b. Was decedent pregnant in the past 12 months?		n 2 🗌 Fetal	death 3	Ectopic pregnanc	у		2	3d. Date of del Month	•	Year
0.	res that the death certific igned by the attending F be detached for use as	Physician/Med	1 ☐ Yes 2 X No 9 ☐ Unknown	4∐Pregnan 9□Unknow	it at time of de n	eath 5[Other (specify) _					,	
٥	that the	Ph	Part II. Other significant conditions	contributing to deat	h but not rest	ulting in the t	ınderlying cause gi	ven in Part I.	23e. Did	tobacco us	se contribute to	the cause of	death?
Records,	uires sign id be	d by							1 🗆	Yes 2]No 3∏Pr	obably 4X	Unknown
202	w requir been si should	lete							24a. Wa	s an	24b. Were au	utopsy findings	available
Re	iician: The lav certificate has rector, page 2	Completed							hed	opsy ormed? 2∑No	prior to death?	completion of a : 2□ No	ause of
Vital	iffication, pa		25. Was case referred to medical			-		26. Place	1 ☐ Yes of Death (Check only		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	20110	
>	Physician: r this certific ral director,	To Be	examiner? 1 ☐ Yes 2 X No	Hospital: 1 ☐ Inp	atient 2	ER/Outpatie	nt 3□ DOA Ot	hon	sing Home 5 Res		☐Other (Spe	cify)	1111
1 of	ding Phys h. After this funeral di		27. Manner of Death 1 √ Natural 5 ☐ Pending	28a. Date of (Month,	Injury Day Year)	28b. Time o	of 28c. Inju	iry at ork?	28d. Describe	how injury	occurred		
Sio	Attending r death.	catle	Accident investigat	bo]Yes 2□N					
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not determine	28e. Place of building	Injury - At ho , etc. <i>(Specif</i>)	ome, farm, si y)	reet, factory, office		28t. Location City or To	(Street and wn, State)	l Number or Ru	ural Route Num	1ber,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific compietely filled in by the funeral director,	edicai Ce	29a. Certifier Certifying (Check only 2 Medical Ex	Physician: To the beaminer: On the basi	est of my kno is of examina	wledge, dea tion and/or in	th occurred at the to	ime, date and opinion, death	place, and due to the	cause(s) , date and	and manner as	s stated.	s)
	To tha h within 2 To the 3 complete	Med	one) 29b. Signature and title of certifier	and manne			29c. Licen	se number		29d. Date	e signed (Mont	h. Dav. Year)	
	To To Io		William A	TIL	MD		046	0998		00	oper	. 11,20	204
A /	19		30. Name and address of person wh	o completed cause	of death (Item	n 23a) (Tuna	Print)	1-1-3	y diame				'
CK	- (3)			le MD	34	ISHA	MLTO	V ST	HYAlto	ville	MD2	0782	_
	St Regist	ate rar	31. Date filed (Month, Day, Year) OCT 1 4 20	04 37 Reg	gistrar's Signa	ture	MLTO						

DHMH 17 Rev 1/2001

DICKOFF

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34134 JAMES DANIELS 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Daniels, Jr. 12, 2004 Sept. 1459 Thomas /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Peninsula Regional Medical Center Wicomico Salisbury If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Director 05-13-1961 Maryland 212-72-1934 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-fahow Examiner must be notified at 1 Yes 2 No Somerset Wenona Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō or items 23a 9010 Deal Island Road deeth 1 21821 USA Funera Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Black. White, etc. within 72 hours after 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: *natural White Completed er than "nature the Medical i 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Seafood Waterman 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be is marked o permit. Pages 1 and 2 should be Department of Health and Mental Important: If Itam 27 is markad i any injury or other traumatic av ဥ Peggy Thomas James Thomas Daniels, Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Jill Daniels/Wife 9010 Deal Island Road, Wenona, MD 21821 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/16/2004 Wenona, Maryland St. Pauls U.M. Cem. 22. Name and Address of Facility Hinman Funeral Home Signature of Funeral Service Licensee M00295 11673 Somerset Ave., Princess Anne, MD 21853 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hypertensive Heart Disease **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760, nding physicien Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, should be 4 Unknown Chronic Obstructive Pulmonary Disease 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2□ No 24a. Was an page 2 autopsy performed 1 Yes certificate Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be caminer? examiner? 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ★ FR/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Injury Attending 1 Naturaf 2 Accident 5 Pending 1 Yes 2 No within 24 hours after death. To the Funerel Director: A investigation the f 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examine: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 O.C.M.E. SEPT. 14, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patricia Aronica-Pollak, M.D. 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygie 20 0 4

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2004year Month **Physician** Oct. 1904 5:35 p.m. Harold Lester ELGIN /Medical 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Beverly Health Care Hagerstown Washington If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Funeral Days Hours 11 M 2□ F Yre March 14 1927 Director 219-20-1357 Maryland Usual Residence of Decedent death with the Maryland 10b County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important; if item 27 is marked other than "netural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 K No Funeral Director Hagerstown Maryland Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20009 Rosebank Way 21740 U.S.A. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Y Yes 2 □ No If Yes, Give Year or Dates: W.W. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify. δ 3 ☐ Widowed 4 X Divorced White II Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 n Officer 0 Prison 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Lester Elgin Helen D. Schultz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Elgin - Daughter 204 Churchwardens Road Baltimore, Md. 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 10/18/04 Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Candro vascular deresse Altheroschentie disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner sete hes been signed by the attending physician and page 2 should be deteched for use es the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Uncerlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 28 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: i or Attending P s efter death. i Director: After t 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital o within 24 hours of To the Funeral Di completely filled in 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 34.3×1 10-18 04 D 28365 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 368 nulls 31. Date filed (Monting Registrar's Signature State Registrar

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2004 34136 For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Day **Physician** Year OCTOBER 9, 2004 MARY **EDELMAN** 5:40 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SUBURBAN HOSPITAL BETHESDA MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1□M 2XF Yrs. Director 083-07-7882 11/02/1912 91 NEW YORK Usual Residence of Decedent the Maryland 10c, City, Town or Location 10a State 10h County 10d. Inside City Limits 28a-f shov In Delition Directo 1 Yes 2 No MARYLAND MONTGOMERY CHEVY CHASE 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? ral', or Items 23a or Examiner must be 20815 8100 CONNECTICUT AVENUE U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: by Specify: 3 XWidowed 4 ☐ Divorced WHITE natural or than "natur Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 TAX COLLECTOR GOVERNMENT 7 la marked other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental I WOLLOWITZ ZELDA BLICKSTEIN WTT.T.TAM 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 41 BIRCHWOOD LANE, HARTSDALE, NY 10530 STEPHEN AXELROD/SON item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o oonce. 1 X Burial 2 ☐ Cremation 3 X Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) BETH DAVID CEMETERY 10/13/2004 ELMONT, NEW YORK of Funeral Service Lic DANZANSKY-GOLDBERG MEMORIAL CHAPELS, 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 23a. Part1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Proviolan THEND SCLERUTC CADIDWACKA disease or condition resulting in death) mymy /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence or) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as the burial-tran Due to (or as a consequence of): P.O. Box 68760, physician certificate be Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 mon Month Year 4☐Pregnant at time of death Day 5 Other (specify) 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ cate has been sig , page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 2 1 🗌 Yes 2 No Physician: director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 | Inpatient 2 ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) 2 1 🗌 Yes Certification: To this 28a. Date of Injury (Month, Day Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending Injury 1 Natural 5 Pending death, 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident rector: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 24 hours e 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 To the

Registrar

State

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Edelman

29b. Signature and title of certifier

O' BRIGH

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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8600

32. Registrar's Signature

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CONSTOUN

29d. Date signed (Month, Day, Year)

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BONTOSWA-

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		For State Registrar		Marylar	•	rtmen tificate			and M		eg. No	104	34137	
Physicia /Medic	al	1. Decedent's Name (First, Middle, Last) LILLIAN ENZEL							2. Date of Death Month OCTOBER			Day Year 12, 2004 11:24 AN		
Examin	G1	4a. Facility Name (If not institution, give street and number) SUBURBAN HOSPITAL					4b. City, Town, or Location of Death BETHESDA If Under 1 Year If Under 24 Hrs. 8, Date of Bit					MONTGOMERY		
Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☐ F								24 Hrs. 8. Date of Birth Min. SEPT 1, 1919 NEW YORK				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural; or items 23e or 28e-f show any injury or other traumatic event, it is Medical Exercitor must be notified at once.	Funeral Director	11. Marital Status	N STREET, APT. #405 12. Was Decedent Ever in U.S. Armed Forces? 1								UNIT	en of What Country? ITED STATES 4. Race - American Indian, Black, White, etc.		
	Completed by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ed. (Specify only highest grade) Elementary/Secondary (0-12) 12				□ Yes 2 No Specify: lent's Usual Occupation kind of work done during most of working OO NOT use retired) [EMAKER			Specify: 16b. Kind of Busines OWN HOME		Business/In	JHITE dustry		
id 2 should be filled Ith and Mental Hyg 27 is marked othe traumatic event.	To Be C	17. Father's Name (First, Middle, Last) MORRIS ENZEL						18. Mother's Name (First, Middle, Maide BEATRICE				en Sumame) HERMAN		
permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 is m any injury or other traum once.		19a. Informant's Name/Relationship (T) ROBERT G. ENZEL, 20a. Method of Disposition 1X Burial 2 Cremation 3 5 4 Donation 5 Other (Specifications) 21. Sign rure of Juneral Service Licens	BROTHE Removal from S BE	20b.	P. O. Place of Dispo cemetery, crer LOM CON	BOX sition (Name of the latery of the latery of the later) IG Cl	3775 ther place EMETI	WA ERY	SHIN 10/1 ERG	3/2004 MEMORIAI	C 200 20c. Location CAPIT CHAP	07 on - City or To COL HE	own, State	
Projected / Medical Examiner Medical Examiner Projected Proj	23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to intimediate cause. Enter Underlying Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 1170 ROCKVILLE PIKE, ROCKVILLE, MD 223a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ASPIRATION PNEUMONIA Due to (or as a consequence of): CONGESTIVE HEART FAILURE Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):											Approximate Interval Between Onset and Death		
that the death certificated by the attending phydetached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 1 Verify								23d. Date of delivery Month Day			•	
es up		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							1 □ Y	23e. Did tobacco use contribute to the cause of death 1 Yes 2 No 3 Probably 4 Unkn				
The ate h page	e Completed	, as Shared and Shared							24a. Was an autopsy performed? 1 Yes 2 X No 1 Yes 2 No			mpletion of cause of		
Phys rthis ral dia	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 X No 27. Manner of Death 1 X Natural 5 Pending investigation 3 Suicide 5 Could not be	28a. Date of Injury (Month, Day Year) n M 28b. Time of 28c. Injury at Work? N 1 Yes 2 No					me 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Num						
Hospitel or Attending 14 hours after death. Funerel Director: Afte tely filled in by the fune											tated.			
To the Hospitel or A within 24 hours after To the Funerel Direct Completely filled in b	Medical	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10/12/04 30. Name and a dress of persyll who completed cause of death (Item 23a) (Type, Print)									Day, Year)			
St Regist	ate	ALPANA GOSWAML, M 31. Date filed (Month, Day, Year) OCT 13 200	32⊿R	.119 RO		E PIK			G-10	00 ROCKV	ILLE,	MD 20	852	

State of Maryland / Department of Health and Mental Hygier 101.

				for State Registrar	State of N	1arylar	nd / Depa <i>Cei</i>	artment <i>tificate</i>	of Hea	lth and M ath		ien 2e () eg. No.	04	34138		
				1. Decedent's Name (First, Middle, Las	t)						2. Date of Death Month Day Year 3. Time of			3. Time of Death		
	Physician /Medical Orlando Flor				res					October		004	19:30 P ^M			
		Examin		4a. Fecility Name (If not institution, give	street and number					n, or Location of Death			4c. County of Death			
				Suburban Hospita	1			Beth				M	lontgo	mery		
		Funeral		Social Security Number 6. Security Number	9X 7. /	lge (In yrs.	last birthday)	If Under 1 Months		Inder 24 Hrs. ours Min.	8. Date of Birth (Month, Day)	Year)	9. Birth	oplace (State or Foreign untry)		
		Director		5/9-64-4298	X III 2 2 1	66	Yrs.				June 17	7,1938	Pe	ru		
		permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinations to other traumatic event, the Medical Examinations to other traumatic event, the Medical Examinations to other traumatic event, the Medical Examinations to other traumatic event, the Medical Examinations are profiled at other traumatic event, the Medical Examinations are profiled at the medical Examinations and the medical Examinations are profiled at the medical Examinations and the medical Examinations are profiled at the medical Examinations and the medical Examinations are profiled at the medical Examinations and the medical Examinations are profiled at the medical Examinations and the medical Examinations are profiled at the medical Examinations and the medical Examinations are profiled at the medical Examinations and the medical Examinations are profiled at the medical Examinations and the medical Examinations are profiled at the medical Examination at the medical Examinations are profiled at the medical Examination at th	or	Usuel Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation		·				10d. Inside City Limits		
				Maryland Montgomery Silver Spring										1 ☐ Yes 2 🛣 No		
			Director	Maryland Montgo	10f. Zip Code						1	0g. Citizen	of What Cou	untry?		
				13604 Middlevale	Tana				2090	16		USA				
		death ms 2	Funeral	11. Marital Status	12. Was Deceder		J.S. 13. \	Vas Decede			ecify Yes or No- Rican, etc.)	14. F	Race - Amer			
	9	after or ite	Ē	1 ☐ Never Married 2 ☑ Married	Armed Force:						Hican, etc.)		Black, White	etc.		
	03	reif, c	i by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	:		Yes 2l	□ NO 3p	ecify: Peruv	ian	Spe	ocify: W	hite		
	5-0	72 h	Completed	15. Decedent's Ed (Specify only highest gra			(Give	lent's Usual kind of work	done during	most of worki	ng	16b. Kind o	f Business/I	ndustry		
	21	ithin er Man	ldu	Elementary/Secondary (0-12)	College (1-4o	r 5+)		DO NOT use	retired)							
	2	led w tygien her ti		17. Father's Name (First, Middle, Last)	4		Archi	tect	10	Mothor's Name	(First, Middle, I		tectu	re		
	and	be fi	Be										iame)			
	2	ould Men narke	2	Juan Flores 19a. Informant's Name/Relationship (7)	Suna Orinti		10h Mailie	an Address (Lucila	Carde		Ctoto 7	in Codo)		
	Maj	d 2 sl th and 7 is r traur	1			12 E -		,								
	altimore, Maryland 21215-0036	1 and Heall em 2		Martha Flores 20a. Method of Disposition	<u> </u>	Vife 20b.	Place of Dispo	sition (Name	9 of				ng Mar on - City or 1	yland 20906 Fown, State		
	nor	nit. Pages artment of ortant: If it injury or o)	1 Burial 2 ☐ Cremation 3 ☐		Gat	cemetery crer e of H				1 0004	a . 1				
	Ħ			* 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Moon			22	emeter Name and	Address of	Facility			- 5	ing,Maryland		
	Ba	Dep den de de de de de de de de de de de de de		All hest	W/L		Fr	ancis	J. Co	ollins I	Funeral	Home,	Inc.	,MD 20901		
		_		23a. Part1. Enter the disease, or com	olications that caus	ed the dea							PL THE	Approximate		
		Physician /Medical Examiner		shock, or heart failure. List only one cause on each line. Immediate Cause (Final										Interval Between Onset and Death		
				disease or condition resulting in death)	a	Primary Hepatoma 6 months Due to (or as a consequence of):								6 months_		
36	Н				b. Chronic Hepatitis C Due to (or as a consequence of):											
\overline{a}_{-}			Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury												
		cuted	Examiner	that initiated avents	c.											
5	0	e exe ian a urial-	Ä	resulting in death) Last	Due to (or a	is a conse	quence of):									
0	8760,	icate be executed physician and s the burial-transit	dical		. d											
1	9	entific ling p	Me	IF FEMALE:	OD- Huma autom											
0	Вох	The could us, T.C. box of the law requires that the death certificate be executed. The law requires that the death certificate be executed at the box seems is the burial-transit case.	lan/	23b. Was decedent pregnant in the past 12 months?	in the past 12 months?						23d.			very Day Year		
	0	the a	Physician/Me	1 Yes 2 No	4 □ Pregnant 9 □ Unknown		oeatn 5∟	JOther (spe	спу)							
	9	uires that the de signed by the a Id be detached f	by		Part II. Other significant conditions c	ontributing to death	but not re	sulting in the u	nderlying ca	use given in	Part I.	23e. Did tol	pacco use c	ontribute to	the cause of death?	
0	Vital Records,	sign d be									1 □ Ye	1 ☐ Yes 2 ☐ No 3 ☐ Proba		bably 4 🖺 Unknown		
2	Ö	w requir been si should	Completed								24a. Was a	n 24	b Were aut	topsy findings available		
g	Rec	has ge 2	dm		-						autops	v l	prior to codeath?	ompletion of cause of		
rland	a	ng Physicien: fler this certifica ineral director, p	e Co	25. Was case referred to medical						70 (70)	1 Yes		1 🗆 Yes	2 No		
0	of		o Be	examiner? 1 \(\sum \text{Yes} 2 \sum \text{No} \)	Hospital: 1 ☑ Inpa	tient 2] ER/Outpatier	t 3 DOA	Othor		Check only on		Other (Spec	1164)		
-				27. Manner of Death	3 DOA 4 Nulsing Hon			me 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred			ny)					
S	on		tolt	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		Jay Year)	7) 28b. Time of 28c. Injury at Work? M 1 ☐ Yes 2 ☐			2 🗆 No						
رو	Division	Attendi r death. ector: A by the fu	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street,					et, factory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)			ral Route Number,		
lore	Ö	tel or A s after al Direct	Certification:	4 ☐ Homicide building, etc. (Specify)								., <i>Otate</i> /				
17		Hospitel 24 hours a Funeral C	Sal (ysicien: To the be											
17		To the Hospitel of within 24 hours at To the Funeral D completely filled in	edical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
		To the within 2 To the complet	Σ	29b. Signature and title of certifier				29c.	License nur	nber	2	9d. Date sig	ned (Month	ned (Month, Day, Year)		
				Mungagu	מיי			D	23308		C	ctobe	r 8,	2004		
		>		30. Name and address of person who												
				Victor M. Priego,						100 Be	ethesda,	Mary1	and	20817		
		Sta	ate	31. Date filed (Month, Day, Year)	14 32,71991	strar's Sign	S	spa	Kel							

State of Maryland / Department of Health and Mental Hygien 2004 1 - For Stata Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** October 6, 2004 5:40 P.M. Shellie Replansky Fine /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Oay, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2 □ F 27, 1953 New York Feb. Director 129-46-3001 Usual Residence of Decedent the Maryland 10c. City Town or Location 10d. Inside City Limits 10a State 10b County 28a-f show other traumatic event, the Medical Examiner must be instilled at †□Yes 2□No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 1333 Winding Waye Lane 20902 U. S. A. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If them 27 is marked other than "Intural", or Items 23e any injury or other traumatic event, Its Mental Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 X No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4+ Therapist Social Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sylvia Golden Samuel Replansky 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Eric M. Fine - Husband 1333 Winding Waye Lane, Silver Spring, Md. 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🎇 Burial 2 🗀 Cremation 3 □ Removal from State Parklawn Menorah Gdns 10/10/2004 Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Edward Sagel Funeral Direction, Inc. 1091 Rockville Pike, Rockville, Maryland 21. Signature of Funeral Service Sonald (20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 90 Minutes Cardiopulmonary Arrest Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 7 Days Respiratory Failure Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Metastatic Breast Cancer 4 Years nding physician and use as the burial-translt death certificate be executed Due to (or as a consequence of): Box 68760, Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Winknown Month Year Dav 5 Other (specify) 4□Pregnant at time of death 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No X No 1 🗆 Yes 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No ٩ this After thi funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation death, 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified D0050748 October 7, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road, Bethesda, Maryland Dr. Tari Roque 32. Registrar's Signature 31. Date filed (Month, Day, Year) **OCT 13** 2004 State

DHMH 17 Rev 1/2001

Registrar

40/9/01

Fine, Shellie

State of Maryland / Department of Health and Mental Hygien 2004 34140 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Janice Ferris October 0 12. 2004 10:35PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's 7536 Surratts Road Clinton 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jan 13, 1928 9. Birthplace (State or Foreign Country) New Jersey 5. Social Security Number **Funeral** 1 □ M 2 X F Months 213 48 8661 76 Vrs Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits r than "natural", or items 23e or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Funeral Director Maryland | Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7536 Surratts Road 20735 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. □Yes 2√√No Yes, GiveXX 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📆 📢 o Specify: þ Specify: 3√√Widowed 4 □ Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Dept Supervisor MD Parole and Probation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nuit. Pages 1 and 2 should be file continuent of Health and Mental Hy content: If item 27 is marked oth injury or other traumatic avani Gedney Miles Rigor Ruth H. Johnson 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynn Ferris (Daughter) 7754 C. St., Chesapeake Beach, MD 20732 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XX remation 3 ☐ Removal from State permit, Page Department of Importent: If any njury or once. Lee Crematory Oct 14, 2004 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc. 21. Signature of Puneral Service Licensee tell, 6633 Old Alexandria Ferry Road Clinton, MD20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIA **Physician** MARSING /Medical Due to (or as a consequence of): **Examiner** CARDIOVASCULAR DISORS THEROSCUEROTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 □ Yes 2 □ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an has autopsy 2001) 2001) certificate 1 Yes Physician: 25. Was case referred to medical examiner? XX No Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred or Attanding 1 🐧 Natural 5 Pending investigation 1 Yes 2 No death. 2 Accident after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral L Certifying Physicien the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai (Check only one) 2 ☐ Medicef Exam the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) nd manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dev. Year) D 22614 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elizabeth Ross M.D. 2021 K Street NW Suite 315 Washington DC 20006 32. Signature 31. Date filed (Month, Day, Year) State OCT 14 2004 Registrar

1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 8 **Physician** 2004 6:35 AM October Hubert Clair Gainer /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Arnold Chesapeake Future Care 8. Date of Birth (Month, Day, Year)
Aug. 11, If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Min Months Days Hours 1 M 2 □ F 1922 West Virginia Director 82 235-32-3419 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10h County or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director <u>Anne Arundel</u> Severna Park Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or tiems 23a any injury or other traumatic event, the Medical Examine any other. 21146 United States 204 Oak Avenue Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 █ No If Yes, Give Year or Dates: 14. Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) agriculture chemical engineer 4 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Josephine Davis Nicholas Gainer 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 204 Oak Avenue Severna Park, MD 21146 Norma Gainer/ wife
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Oct. 12, 2004 Annapolis, MD Hillcrest Cemetery 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License John M. Taylor Funeral Home, Inc 147 Duke of Gloucester St. Annapolis. MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Due to (or as a consequence off) Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequ Examiner Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown s been signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 2 No 3 Probably 4 Unknown 1 TYes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 1 Yes 2 No Division of Vital tha Hospital or Attending Physician: 25. Was case referred to medical examiner? director 26. Place of Death (Check only one, Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 1 🗌 Yes 27. Manner of Death

1 Natural

2 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Injury 5 Pending death. 1 Tes investigation hours after deal 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) py 4 Homicide within 24 hours a To the Funeral I pellil Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 10 10-8-06 30 Name and address of person who completed cause of death (Item 23a) (Type, Print 4204 Mill terans Highwa 8601 State Registrar

Amend item # 10d per FH. G836, 10/26/04 TT State of Maryland / Department of Health and Mental Hygiens 0.01. 1 - For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last, **Physician** 10 2004)ctober /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 1 ENERAL HOSPITA LAMBRIDGE ORCHESTER or chester If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 29, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 ₹M 2 □ F 80 025-14-6603 Yrs. MA Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits or 28a-f show other traumatic avant, the Medical Examiner must be notified at MD Queen Anne's Crumpton 1 Yes No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other then any injury or other traumwith with 79 Adams Drive 21628 USA Itams 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cook Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Richard Patrick Gallagher Anna Marie Bulger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gene Carpenter/Nephew 13 Oak Grove Dr., Apt A, Middle River, MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Cremation Oct. 16, 2004 Stevensville, MD `4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fellows, Helfenbein & Newnam, P.A. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Septree mra Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Renne Aca te Sequentially list conditions, Due to (or as a cons a uence of Examine cause. Enter Underlying Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 HNo funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tyes 2 TNo Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funaral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai completely (Check only one) and manner stated. To tha 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10-11-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 2 16/3 300 AURURA CAMARIAGE NOMAN THANUY STREET 31. Date filed (Month, Day, Year) 32. Register's Signature State

Registrar

OCT 1 3 2004

State of Maryland / Department of Health and Mental Hygienes Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Elizabeth GYSBERTS 200 4 30 an /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 648 N. Mulberry Street Washington Hagerstown 8. Date of Birth (Month, Day, Year) June 22, 1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 ☐ XF Maryland 218-40-3978 Director 62 Yrs. 1942 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a, State 10b, County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at X□ Yes 2□ No Maryland Funeral Director Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 648 N. Mulberry Street 21740 United STates 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🛣 No Specify: White δ Specify: 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Homemaker her own Department of Health and Mantal Hy important: if flem 27 is merked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Merle Wiles Margaret Elizabeth Moyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kim Gysberts 616 N. Mulberry Street dau hter Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Rose Hill Cemetery 10/18/04 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Minnich Funeral Home 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 415 E. Wilson Blvd., Hagerstown, Maryland 21740 esta 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) mounth Examiner Due to (or as a consequence of) month or Attending Physician: The law requires that the death certificate be executed as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 □ No 3 Probably 4 Unknown δ cartificate has been si lirector, page 2 should Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2/200 1 L Yes 1 ☐ Yes 2 ☐ No After this cartification Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 29a. Certifier Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 W 31. Date filed (Month, Day, Year) ----Registrar's Signature

DHMH 16 Rev 6/95

State

Registrar

18 2004

		1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	ertificate		R	eg. No.	34 44		
Physic	ian	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year									
/Med		ALAN LEROY GOLDMA			m, or Location of Dea		8, 2004	11:05 P ^M			
Exami	ner	4a. Facility Name (If not institution, give		atn	4c. County of Deat						
Funeral		8108 APPALACHIAN 5. Social Security Number 6. Se	x 7. Ac	je (In yrs. last birthdaj	POTOMA If Under 1 Y	ear If Under 24 Hr			L hplace (State or Foreign untry)		
Director		229-32-8132 Usual Residence of Decedent	M 2□F	74 Yrs.		ays Hours Mi	01/26/1	930 WASH	INGTON, DC		
anylan show	-	10a. State 10b. County		10c. City, Town or I	_ocation				10d. Inside City Limits 1 ☐ Yes 2 💢 No		
be filed within 72 hours after death with the Maryland ital Hygiene. In the machine of other than "natural", or Items 23a or 28a-f show event. The Medical Examinating must be redified at	Funeral Director	MARYLAND MONTGOME	RY	POTOMAC	404 75- 00	4-		0g. Citizen of What Co	L		
with t	ä	10e. Street and Number	TEDDACE		10f. Zip Co	20854			unity:		
Jeath ms 23	era	8108 APPALACHIAN 11. Marital Status	TERRACE 12. Was Decedent	Ever in U.S. 13	. Was Decedent	of Hispanic Origin? (Cuban, Mexican, Pue		U.S.A. 14. Race - Ame			
after or ite		1 Never Married 2 X Married	Armed Forces? 1 XYes 2 ☐ If Yes, Give	NoARMY	1 ☐ Yes, specify (Black, White				
ours a	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:						VHITE		
"natu	ete	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Dec	edent's Usual Or e kind of work do DO NOT use re	ccupation one during most of w etired)	orking	16b. Kind of Business/	Industry		
withly ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or	5+}	SIDENT	<i></i> 00)		HARDWARE (COMPANY		
Hygi other	Ø	17. Father's Name (First, Middle, Last)	-	1101	LDLINE	18. Mother's N	ame (First, Middle, I		50111 11111		
should be nd Mental marked o	To B	HARRY	GOLDMA	N		MARGARE'	Т	FREIDMAN	1		
permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or ather traumatic once.		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mai	ling Address (St.	reet and Number or I	Rural Route Number	City or Town, State, 2	Zip Code)		
and and man an		GERALDINE GOLDMAN	/WIFE					MAC, MARYL			
Pages 1 nent of H int: If its		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 X	Removal from State		ematory or other	place)		20c. Location - City or			
Definition Pages Separtment of mportant: If it any injury or once.	'	'4 □Donation 5 □Other (Specify					/11/2004 F	ALLS CHURC	H, VIRGINIA		
permit. Page Department Important: If any injury or		21. Signature of Funeral Service Licent	ideure	I	EDWARD S			TION, INC.			
Physician /Medical Examiner		23a. Part1 Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ach line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):									
te be executad ysician and burial-transit	cal Examiner										
the death certifical the death certifical you the attending physical ached for use as the	hysician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	□Ectopic pregn □ Other (specif			23d. Date of delivery Month Day Year			
n 8 5 8	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
Has b	Completed						24a. Was a autops perforr	y prior to d	topsy findings available completion of cause of		
ysician: The is certificate director, pag	Be (25. Was case referred to medical examiner?	eath (Check only on	8)							
l dil	P	1 ☐ Yes 2 ☐ №	Hospital: 1 ☐ Inpati	22.00	Nursing Home Stresidence 6 □Other (Specify) 28d. Describe how injury occurred						
lor Attending Phyafter death. Director: After this in by the funeral	ertification;	27. Manner of Death 1		ury 28b. Time ay Year) Injury		Injury at Work? 1 ☐ Yes 2 ☐ No					
tal or Att rs after d al Direct	O	3 Suicide 6 Could not be 4 Homicide determined						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funera	edicai	29a. Certifier (Check only one) 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
To ti Withii To ti	ž	29b. Signature and title of certifier	^	29c. Li	cense number	9d. Date signed (Monti	h, Day, Year)				
70		ner		1)	1 7	0 002	-4 0	ctober 0	9,2004		
V	7,050%	30. Name and address of person who o	completed cause of	death (Item 23a) (Type COMONS	ton By	#303,	ROCKU	ILLE MI	9,2004		
S Regis	tate trar	31. Date filed (Month, Day, Year) OCT 13 20	32. Regist	rar's Signature	A Territoria	ls!					

Registrar DHMH 17 Rev 1/2001

1 - For Stata Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** October 12:39 PM Hutcheson Donna Jean 2004 13 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner l'eninsula Regional Medicol Center SHisbury Wiconico If Under 1 Year If Under 24 Mrs. 7. Age (In yrs. last birthday) Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 ☐ M 2 🂢 F Yrs. Director 135-36-2402 Usual Residence of Decedent New Jersey June 16, 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2X No Directo Maryland Marion Station Somerset 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Itama 23a 21838 USA 3643 Williams Point Road by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2X Married 6 1 ☐ Yes 2 🗓 No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Public Schools 12 Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be f and Mental P Van Doren Evelyn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21838 19a. Informant's Name/Relationship (Type, Print) of Health Item 27 3643 Williams Point Road, Marion Station, Maryland John A. Hutcheson (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If itel
any injury or otl
ange. 1 ☐ Burial 2 XCremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory October 14,2004 Salisbury, Maryland 21. Signature of Fundrel Service Licensee 22. Name and Address of Facility Holloway Melson Funeral Home PA sean 103 Linden Avenue, Pocomoke City, Maryland 21851 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) C.A.D. Priysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine Cause (Disease or that initiated events burial-tran resulting in death) Last Due to (or as a consequence of): 68760 Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, VALYE DISEASE 1 Yes 2 No 3 Probably 4 Mnknown Completed FAILURE 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? FANLURE OATIC 2[] No 1 TYAS Vital 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Division of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred I or Attanding Patter death. 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the I within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mubble L. Ogbur wo D34593 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Daburn, m.D. 201 Pine Bluff Rd., Suite 25 Salisbury MD. 21801 H. 3 32. Pugistrar's Signature State OCT 1 5 2004 Goode Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygie Pen n L

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene 2004 34146 Certificate of Death Rea. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 16 Physician 2004 9:55 AM Maxine Elizabeth Henson /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecility Neme (If not institution, give street end number) Examiner Williamsport
If Under 24 Hrs. Hours Min. (Month, Dey, May 12 Washington County Williamsport Nursing Home 5. Sociel Security Number If Under 1 Year Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 921 Months Days 1 □ M 2X □ F Vrs 83 Director Maryland filed within 72 hours after death with the Marylend 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County r 28a-f show 1 ☐ Yes 2 No Director Maryland Washington Williamsport 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code r than "natural", or items 23s or the Medical Examiner must be 21795 U.S.A. 16620 Johnson Drive Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Meritel Status Black, White, etc. 1 Never Married 2 Married white 1 ☐ Yes 2 XNo Specify: Baltimore, Maryland 21215-0020 Specify: é 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will be permit of health and Mentel Hygien important: if tem 27 is marked other the any injury or other traumatic event, the page. Hospital Administrative Assistant 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret Myers Warren Brooks 19b. Maiting Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 16620 Johnson Dr. Williamsport Maryland 21795 D. Newton Henson (Husband) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from State Oct. 20, 04 Hagerstown Maryland Rest Haven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. fiery Funeral Home 21 Signature of Funeral Service Licenses 1331 Eastern Blvd. N. Hagerstown Maryland 21742 cellato Approximate tnterval Between Onset and Death 23a. Pert1. Enter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical 24 Howes URO SEPSIS Examiner Due to (or as a consequence of): Examiner The law requires that the deeth certificate be executed es the bunel-trensit Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 XNo CONGESTIVE HEART FAILURE þ 24b. Were autopsy findings 24a. Was an autopsy performed? Be Completed available prio DIABETES MELLITUS completion of cause of death? , page 1 Yes 2 No 1 ☐ Yes 2 ☐ No SPONDYLITIS HNKYLUSING or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 28e. Date of Injury (Month, Dey Year) 28c. Injury et Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation efter death. Director: Af 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide To the Hospital or within 24 hours of To the Funeral D completely filled i 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier Medical (Check only 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature end title of certifier MO D3370C October 24-10 16, 2004 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) N. ARTIZAN WILLIAMSPORT, MD ZI795 TED E. HOWE 31. Dete filed (Mon 0 Par. Y1ar) 2004 32. Registrer's Signature State

DHMH 16 Rev 6/95

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			For State Registrar	State of Man	yland / Depa <i>Cer</i>	irtment of H <i>tificate of I</i>	lealth and Me Death	ental Hygie Reg.		34147
			1. Decedent's Name (First, Middle, Last)				-	2. Date of Death		3. Time of Death
	Physici /Medic		Louise Annebelle 1	HADLEY				Setabor	Day Year	2:40 PM
	Examin		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or	Location of Death		4c. County of Deat	h
			Washington County			Hagerst			Washingt	
	Funeral		5. Social Security Number 6. Sex	IM 2NF	n yrs. last birthday) 7 /. Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye	ar) Co	nplace (State or Foreign untry)
-	Director		218-62-8182 Usual Residence of Decedent	71	74			July 2 19	930 Mar	yland
	yland		10a. State 10b. County	10	0c. City, Town or Lo	cation				10d. Inside City Limits
	a-fsi	ctor	Maryland Washingt	con	Hager	stown				1 ☐ Yes 2X No
	or 28	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	untry?
	ath w		417 Bethlehem Cour				740		U.S.A.	
	er de Items	Funeral		12. Was Decedent Eve Armed Forces?	er in U.S. 13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (Spec in, Mexican, Puerto P	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
36	irs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:	1	☐ Yes 2XX No	Specify:		Specify:	Mite
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-f show he Woolcal Exc. either is ust be motified at	ted	15. Decedent's Edu		16a. Deced	lent's Usual Occupa	ation	16b	. Kind of Business/l	
2	thin 7 e. an "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	KING OF WORK GONE O DO NOT use retired	during most of workin f)	g		
	ed wi	Con	11	0	Ho	memaker			Her own h	ome
ī	be fill ntal H nd oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name			
7 2	ould d Mer narka natic	2	Charles Edgar Myer		405 44-75	- 4.11 - /01 - 4		enore Stu		
Maryland	d 2 sh th and 7 Is r traur		19a. Informant's Name/Relationship (Ty	,			and Number or Rural	_		
	1 an Heal tam 2		JoAnn Hadley- Daug 20a. Method of Disposition		20b. Place of Dispos cemetery, cren	Bethlehem sition (Name of			n Md. 21 Location - City or 1	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic avant, the Modeal Examilitating an once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Rest Have	_	OCCOL		voratorm	Maruland
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m	permi Depar Impor any ir		I truck Lives	tol	41	5 E. Wil	son Blvd.			land 21740
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only or	cations that caused the	e death. Do not ente	er the mode of dying	g, such as cardiac or	respiratory arrest,		Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or as a c	onsequence of):					
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<u>,</u>	execun nand ial-tra	Exar	that initiated events resulting in death) Last	Due to (or as a co	onsequence of):					
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_	- D 01		IE SERVAL S.							
Вох	eath certif attending for use as	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐		Ectopic pregnancy			23d. Date of deliv	•
0	the at	/sici	1 Yes 2 No	4□Pregnant at tim 9□ Unknown	e of death 5	Other (specify)			Month	Day Year
P.0.	The law requires that the death cert ate has been signed by the attendin page 2 should be detached for use a	by Physician/M	Part II. Other significant conditions con	tributing to death but n	ot resulting in the un	iderlying cause give	en in Part I	23e. Did tobacc	o use contribute to	the cause of death?
ds,	signi signi	d by	Acute Renal	Failure	.	,				bably 4 Unknown
Vital Records,	w require been signature should b	Completed	Dichetes A	1011.110				24a. Was an	24h Were aut	opsy findings available
Re	he la e has age 2	omo	Canalia	Heart Fo	1200			autopsy performed	prior to co death?	ompletion of cause of
ā	an: T	Be C	25. Was case referred to medical	11602			26. Place of Death	1 ☐ Yes 2 ☑	No 1 ☐ Yes	2 No
<u> </u>	nysici lis cer direc	To B	examiner? 1 ☐ Yes 2 X No	ospital: 1 Inpatient	2 ER/Outpatient	3 DOA Othe	25		6 ☐Other (Speci	ify)
Division of	ng Pł		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	28b. Time of Injury	28c. Injury Work	at 28	d. Describe how in	njury occurred	
sio	tandileath.	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1 🗆 Y	Yes 2 □ No			
Ξ	or At after of Direct in by	Certification;	4 Homicide determined	28e. Place of Injury building, etc. (S	 At home, farm, stre Specify) 	et, factory, office	28	If. Location (Street City or Town, St	and Number or Rui ate)	al Route Number,
	spital ours s naral l		29a. Certifier 1 Certifying Phys	ician: To the best of m	v knowladge death	occurred at the tim	ne date and place as	nd due to the cause	(e) and manner ac	etated
	To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funaral Director: After this certificate has completely filled in by the funeral director, page 2	edical	(Check only 2 Medical Examir one)	ner: On the basis of exand manner stated	amination and/or inv	estigation, in my op	pinion, death occurred	d at the time, date a	and place, and due	to the cause(s)
	To the Hospital within 24 hours a To the Funaral I completely filled	Me	29b. Signature and title of certifier			29c. License	number	29d. t	Date signed (Month,	Day, Year)
Ų	48		Kerry -			D387	164		10/15/2004	
	5		30. Name and address of person who co	mpleted cause of death	h (Item 23a) (Type, f	Print)	- Heyens) - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	
	Sta	le.	31 Date filed (Month Day Year)	32. Patristrar's	Signature -	S Cu-1	Lie Janie	only	71740	
	Registr		OCT 18 20	04 Secur	Signature	whi				

			For State Registrer	State	of Marylan		artment of I		Mental Hygie	/11114	34148
	Physici	an	Decedent's Name (First, Middle	•						Day Yea	
	/Medio Examir	cal	Walter Lewis F 4a. Facility Name (If not institution		umber) .		. 4b. City. Town. o	or Location of Deat	October	7, 20, 4c. County of D	
	LXamii	ic.	Peninsula Keg	NONS M	ndical c	WHU	51	14/3644		Nico	MICO
	Funeral Director		5. Social Security Number 220–16–9290	6. Sex 1 ⊠ M 2 ☐ F	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	ear)	Birthplace (State or Foreign Country) MD
	/land		Usual Residence of Decedent 10a. State 10b. County		10c. City	/, Town or Lo	cation				10d. Inside City Limits
	death with the Maryland ms 23e or 28a-f show r must be notified at	ctor	MD Wico	mico	Sa	lisbur	У				1 ⊈Yes 2 □ No
	with th	Funeral Director	10e. Street and Number	-a+			10f. Zip Code		10g.	. Citizen of What	•
50,0	ms 23	neral	500 Village Cou	12. Was Dec	cedent Ever in U.	S. 13. V	21801 Vas Decedent of F	Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No-	U.S.	merican Indian,
1400,290	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Menial Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic avent, the Medical Examinar must be notified at once.	þ	1 ☐ Never Married 2 ☐ Marri 3 🛂 Widowed 4 ☐ Divorced	Armed F ed 1 🗆 Yes If Yes, G Year or I	2⊠ No ive		fYes, specify Cub □ Yes 2½ No		to Rican, etc.)	Specify: E	
15-0	n 72 ho "natur edical	Completed	15. Decedent (Specify only highes	s Education t grade completed)	16a. Deced	lent's Usual Occup kind of work done	pation during most of wor d)	rking 16t	o. Kind of Busine	ss/Industry
7 16- 2121	d withi glene. er than	omp	Elementary/Secondary (0-12) 6th	College	(1-4or 5+)		ruck Dri	-		Reta	il
then 2-	be file ital Hy id othe avent,	Be	17. Father's Name (First, Middle,	_ast)				18. Mother's Nar	ne (First, Middle, Mai	den Surname)	
Wall	should nd Men marke matic	٦ ک	Ross Harmon 19a. Informant's Name/Relational	nip (Type, Print)		19h Mailin	a Address (Street	Ida Mae	Duffy Iral Route Number, Ci	ity or Town State	Zin Code)
3 U &	and 2 s alth ar 127 is ar trau		Lydia Harmon/da						alisbury, N		s, <i>Lip</i> 00de)
ore	ges 1 a t of He If item or othe		20a. Method of Disposition 1 Spurial 2 Cremation	3 □Removal from		ace of Dispos	sition (Name of natory or other pla			. Location - City	or Town, State
Baltimore	it. Pag trament ortant: njury o		'4 □Donation 5 □ Other (S	pecify			l Memory Name and Addre		4/2004	Salisbur	y, MD
Ba	Depa Impo any ir		1/1			L	ewis N. V	Watson Fu	neral Home	9 4D 21001	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the death	. Do not ente	er the mode of dyir	ng, such as cardiad	or respiratory arrest,	W 21801	Approximate Interval Between
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	myto	carch	al my	ardion			Onset and Death
	Examiner			Due to	(or as a consequ	ience of):	artern	Oliner	0.		Thu.
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consequ)	000200	The same of the sa		
	cate be executed obysician and the burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a consequ	ence of);					
8760,	ate be e hysician the buris			d							
89 x	ertifica ling ph e as th	Med	IF FEMALE:								
P.O. Box 6	To the Hospital or Attanding Physician: The law requires that the death certific: within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending pl completely filled in by the funeral director, page 2 should be detached for use as t	Physiclan/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live	utcome of pregnar birth 2 Petal nant at time of de nown	death 3	Ectopic pregnancy Other (specify)	у		23d. Date of o	delivery Day Year
Division of Vital Records, P.	uires that signed by lid be deta	þ	Part II. Other significant condition	ns contributing to a	death but not resu	lting in the un	derlying cause giv	en in Part I.	23e. Did tobaco		to the cause of death? Probably 4 IIII Trown
000	law requir as been si 2 should	Completed							24a. Was an	24b. Were	autopsy findings available
E E	: The cate had page	Com							autopsy performed 1 ☐ Yes 2 ☐	2 death	
Vita	siclan certifi irector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No	Hospital:	Inpatient 2 🗆 8	D/O-4	3 DOA Oth	0.5	th (Check only one)		
Jot	ding Physician: The lar n. After this certificate has funeral director, page 2	F 1	27. Manner of Death	28a. Date		ER/Outpatient 28b. Time of Injury	3 DOA 28c. Injur	4 🗆 Nursing 🖯	ome 5 Residence 28d. Describe how in		pecify)
sior	tandln leath. tor: Af the fur	catlo	1 Natural 5 Pending 2 Accident investig 3 Suicide 6 Could r	ation			M 1 🗆	Yes 2 □ No			
Divi	after of Direct of in by	Certification:	4 Homicide determine	ned 286. Plac	e of Injury - At hos ling, etc. (Specify	me, farm, stre)	et, factory, office		28f. Location (Street City or Town, St		Rural Route Number,
	To the Hospital or Attano within 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certifyin (Check only one) 1 Medical	xaminer: On the b	e best of my knov pasis of examinati nner stated.	vledge, death ion and/or inv	occurred at the tir estigation, in my o	me, date and place pinion, death occur	, and due to the cause rred at the time, date	e(s) and manner and place, and d	as stated. ue to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	(A)		70 0	29c. Licens	e number		Date signed (Mo	
			1 K odne	y aw	emich	m.D	V	15384		GCT. 1	2,2004
270			30. Name and address of person of RUDIVEV A.	who completed cau				VST. C	ALISBUR	ey mi	21804
	Sta	_	31. Date filed (Month, Day, Year)	32.1	Registrar's Signat		Ana.	/	, (2)	1 1 1	
	Registr	ar	00114	E004			jajour	· V			

514	4		1 - For State Registrar	State of M	aryland / De	epartmer Pertificat	nt of H	lealth a D <i>eath</i>	nd M	ental Hy	gien Reg. No	004	34149
			1. Decedent's Name (First, Middle, Las	t)			-	_		2. Date of De		V	3. Time of Death
	Physici /Medio		FORBEALIE AN	THONY HU	RT					Octob	er 8	y Year 3, 2004	7:10 P ^M
	Examir		4a. Facility Name (If not institution, give	street and number,)	4b. City,	Town, or	Location of	Death		40	. County of Dea	
			Prince George's 1				ever]						George's
	Funeral		5. Social Security Number 6. So 578-56-1454	ex 7.Ag S⊋M2□F	ge (In yrs. last birtho	Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da	av. Year.	C	thplace (State or Foreign ountry)
	Director	ļ	Usual Residence of Decedent	x -	61 Yrs	·				10/15/	194.	2 Wash	nington, DC
	land ow		10a. State 10b. County		10c. City, Town o	r Location		_					10d. Inside City Limits
	Many it sh	ţŏ	MD P.G.		Capito	l Heia	hts						1√ Yes 2 No
	r 288	Director	10e. Street and Number			10f. Zip					10g. Ci	tizen of What Co	ountry?
	3a o		5411 Emmit Street				20	745				U.S.A.	
	72 hours after death with the Maryland Instural; or Itams 23a or 28a-f show digal Examinate Institled at	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was Dece If Yes, spe			in? (Spe	cify Yes or No)-	14. Race - Ame	
9	after or Ita		1 ☐ Never Married 2 ☐ Married	Armed Forces: 1∑Yes 2 ☐ If Yes, Give	No				Puerto F	ncan, etc.)		Black, Whit	
8	ral',	d by	3 ₩ Widowed 4 Divorced	Year or Dates:	64-68	1 🗆 Yes	2 X 2 140	Specify:				Specify: Bl	.ack
21215-0036		Completed	15. Decedent's Ed (Specify only highest gra-	ucation de completed)	(6	ecedent's Usu	rk done o	durina most	of workin	g	16b. K	(ind of Business	/Industry
12	within ene.	mp	Elementary/Secondary (0-12)	College (1-4or	5+)	e. DO NOT u		•					
2	e filed within al Hygiene. other than ' vant, the Me		12th 17. Father's Name (First, Middle, Last)		EL	ectrica	al Er			ch. (First, Middle		ublic Wo	orks
and	od of	Be	Edward Reginald	Hurt									
Ë	2 should be and Mental is marked c	스	19a. Informant's Name/Relationship (7		10h M	ailing Addross	(Street			Scrugg		CK or Town, State, 2	Zin Condo)
Maryland	s 1 and 2 should I Health and Men Item 27 is marke other traumatic		Regina L. Tucker										and the same
	as 1 and 2 of Health item 27 i		20a. Method of Disposition	- Daugnce.	20b. Place of Di	sposition (Nat	me of		e; E	CW1e,_		land 2	
2	ages nt of t: If if		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	-	crematory`or o		1	0/15	/2004		•	
Baltimore,	permit. Pages Department of H Important: If ite any injury or of		21. Signature of Funeral Service Licen		Haryta	22. Name ar	od Addres	s of Facility					, Maryland
Ba	permi Depa Impo any i		> Oroma Wate	mak)					rre			al Serv	
			23a. Part1 Enter the disease, of companies shock or heart failure. List only of	olications that cause	d the death. Do not	enter the mod	BOX de of dying	416; g, such as c	Suit ardiac or	land,	Mary rrest.	rland 2	0752 Approximate
	Physician /Medical Examiner	ıer	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Campli Due to (br as	carriers of):								Onset and Death
,8260,	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	dlcal Examiner	cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a consequence of):								
.O. Box 6	it the death certific by the attending p tached for use as i	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death	3 ☐ Ectopic pi 5 ☐ Other (sp						23d. Date of del Month	ivery Day Year
<u>.</u>	res that igned b be deta	by P	Part II. Other significant conditions co	ontributing to death t	out not resulting in th	e undertying o	ause give	en in Part I.		23e. Did t	obacco i	use contribute to	the cause of death?
Records,	quire n sig uld b	pe pe	Dia BETES Mellitu	<i>y</i>						10	Yes 2	XNo 3□Pr	obably 4 🗀 Unknown
8	> 20 00	ompleted								24a. Was	an	24b. Were au	stopsy findings available
æ	9 4 9	mc								autor perfo	rmed?	prior to death?	completion of cause of
Vital	ician: Th certificate ector, pag	C	25. Was case referred to medical					26 Place	of Death	1 ☐ Yes Check onl	2) No	1 Tes	2 No
	8 S =	0 0	examiner?	Hospital: 1 🔀 Inpati	ent 2 ☐ ER/Outpa	tient 3 DC	Othe					6 ☐Other (Spec	cifu)
Division of		h ii	27. Manner of Death	28a. Date of Inju	ıry 28b. Tim		28c. Injury Work		_	d. Describe I			sayy
ion	Attanding r death. sctor: Afte	atlo	1 □ Natural 5 □ Pending 2 □ Accident investigation	(Monto, Da	ly Year) Inju	OPM	1 🗆)	i: ∕es 2∭XN	0	Miller	anl		
Vis		ific	3 ☐ Suicide 6 Could not be determined	28e. Place of In	jury - At home, farm, tc. (Specify)	street, factor	y, office		2	of Location (Street ar	nd Number or Ru	iral route Number,
Ö	tal or s afte al Dir	Certification:	TISHIO.GO	building, e	Vesid	erce			(Lanina	Heir	hte mis	my street
	To tha Hospital or within 24 hours afte To the Funaral Dircompletely filled in		29a. Certifier 1 ☐ Certifying Phy (Check only 2 ☑ Medical Exam	/sician: To the best	of my knowledge, d	eath occurred	at the tim	e, date and	place, a	nd due to the	cause(s)	and manner as	stated.
	tha h iin 24 the F iplete	ledical	one)	iner: On the basis of and manner st	ated.				occurre	at the time,	uate and	place, and due	to the cause(s)
	To tha within 2 To the complet	Σ	29b. Signature and title of certifier	1 11		290	c. License	number			29d. Da	te signed (Monti	h, Day, Year)
	0//			M. IL			0.C.1	M.E.			Octo	ober 10,	2004
4	1750		30. Name and address of person tho o		death (Item 23a) (Ty								
4	IVA		JACK M. TITUS	-		111	Peni	n Stre	æt,	Baltin	ore	, Maryla	and 21201
	Sta	ite	31. Date filed (Month, Day, Year)	Registr	rar's Signature	-							

State of Maryland / Department of Health and Mental Hygie 2004

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2:25 P M OCTOBER 11,2004 HUNTER HAWKINS /Medical 4c. County of Death 4h City Town or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ANNE ARUNDEL CROFTON CONVALESCENT REHAB. CENTER CROFTON | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yill Mark H.) | MARCH 1, 1 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** WASHINGTON, D.C 1 ☐ M 2 🗹 F Yrs 579 16 9627 83 Director Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other treametic event, it a Madical Evaninational be rottlind at ance. 1 ☐ Yes 2 No Directo ANNE ARUNDEL ODENTON 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number UNITED STATES 21113 707 HARVEST RUN DRIVE Funeral 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 28 No Specify: Baltimore, Maryland 21215-0036 Š WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) TELEPHONE OPERATOR U.S. GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ETTA DELORES COCKRELL JOSEPH NATHANIAL HOLLAND 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) RICHARD EARL HAWKINS, HUSBAND 707 HARVEST RUN DRIVE, ODENTON, MD. 21113 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State MT. TABOR CEMETERY 10/16/04 ETCHISON, MD. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee MURTEL Address ARBER FUNERAL HOME arke Wil 5038 LAYTONSVILLE, MD. 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of **Examiner** esicu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-transit Due to (or as a consequence of) Box 68760. Completed by Physician/Medicai IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒ No 3 Ectopic pregnancy Year Month Day for 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the a 9☐ Unknown 9 Tilnknown 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan page 2 s Jas 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Ceath Certification: After Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No after death. investigation 2 Accident the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide within 24 hours after de To the Funerel Directo completely filled in by th 4 | Homicide To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check or one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Q 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANNAPOUS, MD PD 31. Date filed (Month, Day, Year)

OCT 13 2004 32. Registrar's Signature State Registrar

		•	For State Registrar	State	of Ma	ryland	d / Depa <i>Cer</i>	rtmen tificate	t of He e <i>of E</i>	ealth an Death	nd Mei		gien e Reg. No.	004	34151
	Physici		1. Decedent's Name (First, Middle, Sheryl Ann H	,								Date of De. Month Ctobe:	Day		3. Time of Death a M 1:15
	/Medic Examin		4a. Fecility Name (If not institution,	give street and n	umber)					Location of C			4c.	County of Dea	ath
	Funeral Director		4016 Havard St. 5. Social Security Number 213-82-1149	reet .Søx 1□M 2\$□F	7. Ag <i>e</i>		ast birthday) 8 Yrs.	If Under Months		Spri If Under 24 Hours	Hrs. 8.	Date of Bird (Month, Da ug. 27	v. Year)		omery hhplace (State or Foreign ountry) ryland
Propins of A		tor	Usual Residence of Decedent 10a. State 10b. County	omerv			Town or Loc					<u> </u>			10d. Inside City Limits 1 ☐ Yes 2 【\$\text{No}
4	or 28e	Director	10e. Street and Number	OMCLY		<u> </u>	LVCI	10f. Zip	Code				10g. Citi:	zen of What C	ountry?
	permit. Pages I and 2 should be lifed within 72 hours stills floats with the waryand Department of Health and Mental Hygiene. Important: If time X7 is marked other than "nature!", or iteme 23a or 28e-f show any injury or other treumatic event, the Medical Examinat must be indiffed at ance.	by Funeral	4101 Havard Str 11. Marital Status 1 □ Never Married 2 ☑ Marrie 3 □ Widowed 4 □ Divorced	12. Was De Amed	Forces? s 2 1 No Give					spanic Origin , Mexican, F Specify:	n? (Specif Puerto Ric	y Yes or No can, etc.)	1	USA 14. Race - Am Black, Whi Specify: Wh	ite, etc.
200	mun /z nou ne. han "naturel e Medical Ex	Completed b	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade complete		+)	life. E	kind of wor OO NOT us	rk doné d se retired)	uring most o				nd of Business	Sovernment
ומוומ ל	ld be liled viental Hygie ked other t	To Be Co	17. Father's Name (First, Middle, La Ralph John Col		ł		Fir	ancı		fficer 18. Mother's Clau	Name (F	First, Middle,	Maiden		overment
iai y	and M		19a. Informant's Name/Relationshi	p (Type, Print)			19b. Mailin	g Address	(Street a	nd Number	or Rural F	Route Numbe	er, City o	r Town, State,	Zip Code)
	rages I and nent of Heelth int: If item 27		Robert Hogan/ H 20a. Method of Disposition 1 ★Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	B □Removal fro	m State	CE	ace of Dispos	sition (Nari natory or o f Hea	ne of ther place	-33	Date	er 13	20c. Lo	cation - City o er Spr:	
ממוב	Departm Departm Imports any Inju		21. Signature of Funeral Service Li	J. Col	2		F1 50	Name and and and and and and and and and and	s J. iver:		Blvd,	W, S:	llver	ne Inc Sprin	g, MD 20901
F	าเงราะเลก		23a. Part1. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final disease or condition	omplications than the cause of				er the mod	e of dying	, such as ca	urdiac or r	espiratory a	rrest,		Approximate Interval Between Onset and Death 2 Years
ı	/Medical Examiner		resulting in death) Sequentially list conditions.	b. ———	to (or as a										
,0070	icate be executed physicien and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	to (or as a										
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cords, r	law requires that the de- as been signed by the a 2 should be detached f	by	Part II. Other significant condition	s contributing to	death bu	it not resu	ulting in the ur	nderlying o	ause give	n in Part I.			obacco u Yes 2 1		to the cause of death? Probably 4 Unknown
Ē	The ate h	Completed									_			prior to death?	autopsy findings available completion of cause of
	ter t	tion: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investig.	28a. Da (M	☐ Inpatier te of Injur lonth, Day	y	ER/Outpatien 28b. Time of Injury		8c. injury Work	r: 4 🗆 Nurs	ing Home	Check only of the Check on the Ch	dence (ecify/Brother's Residence
DIVISION	al or Attending s after death. Il Director: After id in by the fune	Certification:	3 Suicide 6 Could n 4 Homicide determin	ot be 28e. Pla	ace of Inju ilding, etc		ome, farm, str	eet, factor	y, office		28	f. Location (City or To	Street an wn, State	d Number or F)	Rural Route Number,
	e Hospital of 24 hours a e Funeral Dietely filled i	edicai (examinat									as stated. ue to the cause(s)
	To the transfer of the transfer complete	Me	29b. Signature and title of certifier	λ	5		\	29	c. License		-				nth, Day, Year)
3	10		30. Name and ad ress of person v	no completed c	ause of de	eath (Item	23a) (Type,	Print)	D4!	5880		- Walin	Oc	ctober	12, 2004
	C+	ate	Leon C. Hwang 31. Date filed (Month, Day, Year)		. Registra	ır's Signa	card [N.			e, M	D 2085	50		
	Reaist		not 13	2004	2 Dogod	of protect	13	AG	me Ka	C. Tolk					

		For State Registrar	tate of Maryland	d / Depa <i>Cer</i>	irtment of H tificate of L	ealth an Death		giene	004	34152
² Physicia	n	Decedent's Name (First, Middle, Last)					2. Date of Dea		o o Year	3. Time of Death
/Medica	al .	Aaron Joseph Hoy 4a. Facility Name (If not institution, give stre	ot and number)		4b. City, Town, or	Location of F			2004	8:45 A M
Examine	er	Beverly Health Care			Frederic	_)eath		ederic	
Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. In	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Birt (Month, Day Feb. 15	y, Year)	Co	hplace (State or Foreign untry) yland
		Usual Residence of Decedent		-			100. 13	,	o ilui	
ath with the Marylan s 23a or 28a-f show ust be notified at	5	10a. State 10b. County Marvland Frederick		town or Local derick						10d. Inside City Limits 1 ¹ E Yes 2 □ No
the N	rect	Maryland Frederick 10e. Street and Number	FIE	delicr	10f. Zip Code			10g. Citizer	n of What Co	untry?
h with	<u>a</u>	999 Heather Ridge Dr	ive		21702			Unite	d Stat	es
ltam Itam	y Funerai Directo	1 ☐ Never Married 2 ☐ Married	Was Decedent Ever in U.S Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give T.T.T.T.T.	li li	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 ^N No	spanic Origin n, Mexican, P Specify:	? (Specify Yes or No- uerto Rican, etc.)		Race - Ame Black, White	e, etc.
Maryland 21215-UU36 d 2 should be filed within 72 hours af the and Mental Hygiene. 27 is marked other than "natural; or traumatic event, the Mudical Exum.	ed by	3€ Widowed 4 Divorced 15. Decedent's Educati	If Yes, Give Year or Dates: WWII	16a Deced	ent's Usual Occupa	ation			of Business/	
d Z1Z13- filed within 72 Hygiene. other than "natent, ine Mydic	Completed	(Specify only highest grade co	College (1-4or 5+)	(Give	kind of work done of OO NOT use retired	furing most of	working	IOD. KIIIG	OI DUSINES SA	mousty
d 212 filed withi Hygiene. other than	Som	9	College (1-401 54)	Carpe	enter			Montg	omery	County
be file	Be	17. Father's Name (First, Middle, Last)					Name (First, Middle,	Maiden Su	mame)	
arylan should be and Mental marked o	င္	Calvin Hoy 19a. Informant's Name/Relationship (Type,	Print)	19b Mailin	a Address (Street a	Velva	Stanton or Rural Route Number	r City or Ti	num State 7	in Code)
		Geraldine James / Da								and, 21702
Ore, Maryla ss 1 and 2 should b of Health and Ment filtam 27 is marked r other traumatic		20a. Method of Disposition	20b. Pi		sition (Name of natory or other place		Date		ion - City or	
Pages Pages ment of ant: If Its ury or o		1 Burial 2 Cremation 3 Rem '4 Donation 5 Other (Specify)	Oval IIOIII State	dville	Cemetery	7 10	-14-2004		-	
Baltimore, permit. Pages 1 ar Department of Hea Important: If Itam: any injury or othat		21. Signature of Funeral Service Licensee Bradley J. J.	refer	1	621 Oposs	umtown	Stauffer Fu Pike/ Fre	ederio		-
Physician		23a. Part1. Enter the deease of complicat shock, or heart failure, just only one of immediate Cause (Final disease or condition	ions that caused the death ause on each line.			g, such as ca	rdiac or respiratory ar	rest,		Approximate Interval Between Onset and Death Week
/Medical Examiner		resulting in death)	Due to (or as a consequ Prostate Can	ence of):	E					Week
ted nsit	Examiner	if any, leading to immediate	Due to (or as a consequ							Years
execunate and and all-trains	Exar	that initiated events c resulting in death) Last	Rheumatoid Due to (or as a consequ	ence of):						
876(cate be chysicia the bur	dicai	d	<u>Diabetes Mel</u>	litus_						Years
death cert e attending	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3	Ectopic pregnancy Other (specify)			23d	. Date of deli Month	very Day Year
	Completed by Pl	Part II. Other significant conditions contrib Failure to thrive, A				en in Part I.				the cause of death?
aw require s been sig 2 should t	piete	Hypertension, Throm	bocytopenia				24a. Was		4b. Were au	topsy findings available
	Som	Gastroesophageal Ref	lux Disease				— autop perfor 1 ☐ Yes	med? 2½ No	death?	ompletion of cause of 2√2 No
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hys his	ဥ	T THE ZEA ING	1 Inpatient 2 1	ER/Outpatient 28b. Time of		4 FNUISII	ng Home 5 🗌 Resid			sify)
VISION Of VITA Attending Physician: r death. ector: After this certific by the funeral director.	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	28c. Injury Work M 1 🔲	.? ∕es 2 □ No		on injury o		
DIVISION OF all or Attending Physical death. I Director: After this din by the funeral di	Certification:	a Could not be	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	eet, factory, office		28f. Location (S City or Tow		lumber or Ru	ral Route Number,
	Medical C	29a. Certifier 1 Certifying Physici (Check only one)	an: To the best of my know On the basis of examinat and manner stated.	vledge, death ion and/or inv	occurred at the tim estigation, in my op	e, date and p pinion, death o	place, and due to the o occurred at the time, o	cause(s) and date and pla	d manner as ace, and due	stated. to the cause(s)
To th within To th comp	M	29b. Signature and the of certifier	Reilly	MD	29c. License D54749			29d. Date s 10/11/	igned (Month 2004	, Day, Year)
3+1		30. Name and address of person who comp Allen Reilly, MD, 8	//							
Star Registra	_	31. Date filed (Month, Day, Year) OCT 14	32. Registrar's Signat	ure	5 pp	aks	,			

State of Maryland / Department of Health and Mental Hygien 2004 34153 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** HELEN LOUISE IDLEMAN 03:05 M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death umber lanc Allega HOSPITA If Under 1 Year | If Under 24 Hrs. 8. 5. Social Security Number ge (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Days Hours 1 □ M 2 □ F 234-38-8812 Director 6-28-1928 WV Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits Hygiene. other than "naturel", or Items 23a or 28a-f shov ent. The Medical Expiriting must be notified at Director 1 XYes 2 No Grant Petersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1001 Michael Avenue Funeral 26847 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☐ No þ 3 Widowed 4 □ Divorced Specify: white Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Magistrate Assistant Grant Co. Magistrate Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fi and Mental H is marked of rmit. Pages 1 and 2 should be partment of Health and Menta portant: If item 27 is marked y injury or other traumatic •• Henry H. Cosner Myrtle Moreland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas T. Idleman/son 9275 Highway 42 South Maysville, WV 26833 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State **⊠** Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Scherr-Idleman Cem. 10-22-04 Scherr, WV 22. Name and Address of Facility Scarpelli Funeral Home, PA for 21. Signature of Funeral Service Licensee Schaeffer FH 11 N. Main St., Petersburg, WV 26847 Anter the disease, or complications that caused the death. for heart failure. List only one cause on each line. 23a. Part1 Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease of condition resulting in death) **Physician** metastat lung /Medical Due to (or as a consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 23e. Did tobacco use contribute to the cause of death? 1 Pes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed of Vital 1 ☐ Yes 2 ☑ No or Attending Physician: filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No Certification; To 1 ☐mpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred : After 1 🕒 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) unanjunaan, n.D. October 19, 2004 D56207 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HUSAM SEMAAN, M.D. SACRED HEART HOSPITE CUMBERLAND MD 21502 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

State of Maryland / Department of Health and Mental Hygier 004 34154 1- State Registra AMEND#16a, bperFH10/19/04, BW, McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 10 Year 6:31 PM Karen Sator Jackson 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Holy Cross Hospital Spring Prince Georges Silver 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 ☐ M 2 🖾 F 59 577-62-3078 Director 28,45 | Washington, DC March Usual Residence of Decedent with the Maryland show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23e or 28a-1 show any injury or other treumatic event, the Madical Examiner must be multiled at once. Md. Director Prince Georges 1 ☐ Yes 2 X No Springdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9003 Taylor St. 20774 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black ģ 3 ☐ Widowed 4 🂢 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) School Teacher Education Private 12 Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Gene D. Sator Constance G. Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gene D. Sator/ father 9003 Taylor St., Springdale, Md. 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State Mount Olivet Cem. Oct. 16,04 Washington, D.C. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Universal Mortuary 21. Signatu Funeral Service Licensee 411 Kennedy St., N.W. Washington, DC20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Pneumonia Aspiration Sequentially list conditions, if any, leading to immediate cause find line the cause followed or injury that initiated events Due to (or as a consequence of): Examiner death certificate be executed the attending physician and hed for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 should b End Stage Renal Disease 1 Tes 2 No 3 Probably 4 X Unknown Completed Encephalopathy 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 X No To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 Unpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15% Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 119609 Mucel 10.10.64 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raman Tuli Darnestown Rd., Suite 202 Gaithersburg, Md. 20878 10810 31. Date filed (Month, Day, Year) OCT 13 32. Registrar's Signature oaks Registrar

State of Maryland / Department of Health and Mental Hygien 2004 1 - For State Registrat Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day MAMIE ALLEAN JOLLEY /Medical Sept. 30 2004 2:45 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WILLIAM HILL MANOR EASTON
If Under 1 Year If Under 24 Hrs. TALBOT 5. Social Security Number 8. Date of Birth (Month, Day, Year) Feb. 25, 1923 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 1 F Days Hours Mary Land Yrs. Director 214-12-6156 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland anen of Health and Mental Hyglene.
nnt: If Item 27 is marked other than "natural", or Items 23a or 28a-f show try or other tran. 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Director 1 Yes 2 No Maryland Talbot Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 501 Dutchman Lane Funeral 21601 IISA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify. δ Specify. Black ted 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Complete Elementary/Secondary (0-12) College (1-4or 5+) 9 Private Sitting Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Camper Waters Margaret 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sharon Rideout / Daughter 113 Davis Lane, Federalsburg, Maryland 21632 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page Department o Important: If any injury or once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) Federal Hill Cem. 10-05-2004 Federalsburg, Maryland 22. Name and Address of Facility Funeral Home Bennie Smith Funeral Home 516 S. Main Street, Hurlock, Maryland 21643 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) obstructive pulmonary discase **Physician** 10415 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending physic for use as the b IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ þ cautid occlusion 1 es 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has performed? 1 Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No Other: 5 Residence 6 Other (Specify) dig 2 2 ER/Outpatient 3 DOA s after death.
I Director: After this
d in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print).

WOREH ALLIEN, MD 2195. Washington St Easton un 2/6 01 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar

Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 11, 2004 10:00 A M Mary K. Kousoulas 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Bethesda 6252 Clearwood Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1 ☐ M 2 🔀 F 302.14.7563 80 Yrs. 1924 Jan. Mt. Vernon, OH Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Montgomery Bethesda 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6252 Clearwood Road 20817 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 Tyes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Katris Angelica Manoliadis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dimitrios Kousoulas - Spouse 6252 Clearwood Rd., Bethesda, MD 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location · City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Oct.14,2004Silver Spring, MD Gate of Heaven * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Schice Licenses 5130 Wisconsin Ave. N.W., WDC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heaft failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Chronic Obstructive Pulmonary disease year Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertension 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 ANO 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Z ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 XNo Other: 4 ☐ Nursing Home 5 XResidence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred XXNatural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Examiner the attending physicien and ned for use as the burial-transit 68760, Box P.O. signed by Records, certificate Division of Vital After or Attending after death. To the Hospitel within 24 hours at To the Funerel D

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

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rthan "natural", or Iteme 23a or 28e-f shov the Medical Expriner rount be mutified at

marked other

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Examiner

Physician/Medical

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Certification:

Medical

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page 2 should

funeral director.

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filled in by

Legal 1 and 2 should be file Lepartment of Health and Mental Hyg. The protects: if item 27 is marked thy injury or other the 28.

permit. Page Department of Importent: If any injury or

Physician

/Medical

72 hours after

Maryland 21215-0036

Baltimore,

State Registrar

31. Date filed (Month, Day, Year)

Joe X Schulman, M.D.

29b. Signature and title of certifier

13 2004

30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

6000 Executive Blvd. #300, Rockville, MD oorks

29c. License number

D20516

29d. Date signed (Month, Day, Year) October 12, 2004

				Tease 1 - State Registrar	State of Mar	yland / Depa	artment of H	lealth and N			
					-41	Cei	tificate of	Death	Reg.	1200L	34157
		Physici	an	1. Decedent's Name (First, Middle, La		•			Month	Day Year	5:50 P M
		/Medic		4a. Facility Name (If not institution, giv	LEE KELLOGO	7	4h City Town o	r Location of Death	OCT.9,200	4c. County of Dea	
		Examir	ier	Joseph Richey H				imore		-	
		Funeral		5. Social Security Number 6. S		'In yrs. last birthday)	If Under 1 Year		8. Date of Birth	Baltimor	
		Director			□M 2 X F	44 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye Jan. 10, 1	960 Wa	thplace (State or Foreign buntry)
		р. "		Usual Residence of Decedent							
	:	e Marylau ie-f show	ctor	Md. State 10b. County Prince	Georges	Oc. City, Town or Lo	Forestvi	lle			10d. Inside City Limits Y☐ Yes 2 ☐ No
The	:	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "naturel", or Items 23e or 28e-f show emportent: If Item 27 is marked other then "naturel", or Items 23e or 28e-f show importent: Item 27 is marked other then "and other the month of the page o	Funeral Director	10e. Street and Number 4107- Forestvi	lle Rd.		10f. Zip Code 20	0747	10g.	Citizen of What Co USA	ountry?
0		ems ems	ner	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Ame Black, Whit	
5	98	or it	Ϋ́F	1 Never Married 2 Marned	1 ☐ Yes 2 No If Yes, Give		1 ☐ Yes 2 ☐Xio		, 5151,	Specify: Wh	·
10	2-0036	urel',	Completed by	3 ☐ Widowed 4 ☑ Divorced	Year or Dates:						
9)	<u>1</u>	n 72 "nat	lete	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Deced	ient's Usual Occup kind of work done o	ation during most of work d)	ing 16t	b. Kind of Business	/Industry
	2121	withii ene. then ne.	ш	Elementary/Secondary (0-12)	College (1-4or 5+)		shier	4/		Retail	
B	9	filed Hygi other		17. Father's Name (First, Middle, Last,)			18. Mother's Nam	e (First, Middle, Mai	den Sumame)	
	la I	Mental	To Be	Emmett C. Ether					h Burch		
0	-	and 2 sho salth and I n 27 Is mu		19a. Informant's Name/Relationship (Ruth Etheredge-					al Route Number, Ci Forestvi		
6	0	Pages 1		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specif	Removal from State	20b. Place of Dispo cemetery, crer Metropoli	natory or other plac	ce)		. Location - City or Lexandria	
10	3altir	Departme Departme Importen eny injur		21. Signature of Funeral Service Licer			. Name and Addres			characta	, va.
~	_	4 C1 = 0 OI		w. m. la	119611		6510-1	6th St. 1	W Wash	DC	
				23a. Part1. Enter the disease, or com- shock, or heart failure. List only	one couse and line.	e death. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arrest,	. 1	Approximate Interval Between On <u>se</u> t and Death
	F	Physician		Immediate Cause (Final disease or condition	a em	MUMO	ワウナロイ	MG (1)	11/1 M	175	Olisal and Death
		/Medical Examiner		resulting in death)	Due to (or as a	consequence of):	0,709	7	# 10 m		7,-
		LXGIIIIIIO	L	Sequentially list conditions,	b						/
5		ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a o	consequence of):					
5		ate be executed nysician and he burial-transit	хап	that initiated events resulting in death) Last	C. Due to (or as a	consequence of):					
0	760,	be exician buria	calE		546 10 (6) 43 4 6	onsequence or,					
7		phys phys the	dlc	•	_d						
177	×e	leath certificate attending phy I for use as the	Physician/Medi	IF FEMALE:	23c. If yes, outcome of	pregnancy				22d Data of dal	
V.	B ₀	death e e atten	lan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at tin	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	Day Year
	o l	0 0 0	iyslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	10 07 death 3 E	Ottlet (specify)				/
	ο.	requires that the een signed by th nould be detache		Part II. Other significant conditions of	ontributing to death but i	not resulting in the u	nderlying cause give	en in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
١-	SD	uires that signed to ld be det	d by						1 ☐ Yes	2 □ No 3 □ Pr	obably 4 Dunknown
2		S 0 S	Completed	,					24a. Was an	246. Were au	itopsy findings available
12	Be .	8 8 8	E C						autopsy performed	prior to death?	completion of cause of
17		n: T ficate or. pa	e C	25. Was case referred to nedical					1 Yes 2	No 1□Yøs	2 No
1	5	Physicien: this certific ral director,	o Be	examiner?	Hospital:	2 C EB/Outpation	Othe		h (Check only one)		1/22011 a
		Phys r this ral dii	\vdash	27. Mannyl of Death	28a. Date of Injury	2 ER/Outpatien 28b. Time of		+ in rear string the	me 5 Residence 28d. Describe how in		City) HERVILLE
D	o	ding th. Afte fune	tlor	1 1 atural 5 Pending 2 Accident investigation	(Month, Day Y	'ea <i>r)</i> Injury	28c. Injury Work	k? Yes 2 ∐No		,,,	/
	Division	Atten deal ctor	flca	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of Injury	- At home, farm, str			28f. Location (Street	and Number or Ru	ıral Route Number.
	á	after Dire	Certification;	4 Homicide	building, etc. ((Specify)	,		City or Town, St	ate)	
		To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier 1 Certifying Ph	ysician: To the best of r	ny knowledge, death	occurred at the tim	ne, date and place,	and due to the cause	e(s) and manner as	stated.
		n 24 n 24 se Fu	Medical	(Check only 2 ☐ Medical Exar	niner: On the basis of ex and manner state	camination and/or inv	estigation, in my or	pinion, death occur	ed at the time, date	and place, and due	to the cause(s)
		To the within 2 To the complet	Ĭ	29b. Signature and title of certifier	1/100	110	29c. License	e number	29d.	Date signed (Month	Day, Year)
				1/1/1/1/1//////////////////////////////	MILLAN	M	DI	30/2		10/10/1	04
	a /			30. Name and address of person who	completed cause of deal	th (Item 23a) Type,	Print)	101	2 11	1/1/10	
(1	- 0		JOHNW TAVAR	1111 40	3/1 MANN	rWDD	1 11	DIHIMI	C MA	2/2/8
		Sta	-	31. Date filed (Month, Day, Year)		Signature		1/4	011110	1	
		Registr	ar	OCT 1 4 200	14 Dien	A POR					

			1 - For State Registrar	S	tate of	Maryland	d / Depa <i>Cei</i>	artmen rtificat	t of H e of L	ealth a	and M	F	Reg. No.		4		158
Н	Physici	an	Decedent's Name (First, Min									2. Date of Dea Month	Day	200	/ear		of Death
	/Medic		Patricia	Ann		Kilroy	7		-177			Octobe		2004		7:30	Ct W
į.	Examin	er	4a. Facility Name (If not institu			ber)		- 2.	,	Location of			4c.	County of Mon t		orn	
			15316 Durant			Ann /In usa In	ne hiethdaul	II Under		If Under		8. Date of Birt	h				or Foreign
	Funeral		5. Social Security Number	6. Sex 1 ☐ M	2[3 kF '	. Age (In yrs. la		Months	Days	Hours	Min.	(Month, Day	y, Year)		Cour	ntrv)	on, DC
	Director		577-54-6794 Usual Residence of Decedent					ll					,			5 -	
	iand ow		10a. State 10b. Cou	nty		10c. City	, Town or Lo	cation							1		City Limits
	Mary Fish	ţō	Maryland Mor	tgomer	v	Si	lver	Sprin	q							1 □ Y∈	s 2 G∏No
	28a	rec	10e. Street and Number	- 3		1		10f. Zip					10g. Citi	zen of Wh	nat Cour	ntry?	
	within 72 hours after death with the Maryland ene. then "neturel", or items 23e or 28a-f show the Medical Evant for must be notified at	by Funeral Director	15316 Durant	Stree	+				2090	5				USA			
	ms 2	Jer	11. Marital Status			lent Ever in U.S	S. 13.	Was Dece			gin? (Spe	city Yes or No- Rican, etc.)		14. Race	- Americ	an Indian,	
ယ	after or its	교	1 Never Married 2K	Married	1 ☐ Yes 2 If Yes, Give	2 ⊠ No	į.	1 ☐ Yes				tiodii, oto.,		Specify:	Whi		
ğ	ref., c	by	3 ☐ Widowed 4 ☐ Divor	ced	Year or Da	tes:		1 1 1 1 1 1 1 1 1	2 23 140	эрвену.				эрвену.			
2	72 hc	etec	15. Dece (Specify only his	dent's Educat	ion ompleted)		16a. Dece (Give	kind of wo	rk done d	<i>turing</i> mos	t of workii	ng	16b. Ki	nd of Bus	iness/In	dustry	
21215-0036	ithin Ne.	npi	Elementary/Secondary (0-1	2)	College (1-	4or 5+)		DO NOT u)							
7	filed w Hygier other th	Completed	12	" 4 - "			Hor	nemak	er	10 Moth	or's Namo	(First, Middle,		own H			
nd	be fill d oth	Be	17. Father's Name (First, Mid												,		
Maryland	Men Men arke	2	Pasquale D'				1		(0)			ose DiF				Codel	
<u>Jar</u>	2 sh and is m		19a. Informant's Name/Relati									/ Route Numbe					
	end leelth m 27 her t		Dennis E. Kil	roy/ H	usband		ace of Dispo					Silver				20905 own, State	
Ore	if its		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremati	on 3 □Rem	oval from S	tate G	emetery, create of	matory or o	ther plac	е) (er 13					1 a m d
Ē	Pag ment tent:		`4 □Donation 5 □ Othe				Ceme	tery		1	200					y, Ma	ryland
Baltimore,	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Deperment of Heelth and Mental Hygiene. Importents: If Item 27 is marked other then "neturel", or items 23e or 28a-f show enry injury or other traumatic event, it a Medical Examinar must be notified at once.		21. Signature of Foneral Sen	ice Licensee	1-Col	2e	F 5	name ar ranci: 00 Un:	iver	Coll sity	ins Blvd	Funeral , W, Si	Hon 1ve	ne In Spr	c. ing	, MD	20901
8760,	death certificate be executed Medical Exam di for use as the burial-transit	dicai Examiner	shock, or heart lailure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a b c d	Rect Due to (d	urrent or as a consequ or as a consequ or as a consequ	ience of):	gioma								Onset an	d Death
.O. Box 6	death certific e attending p id for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 Yes 2 No 9 Unknown	23c	1 Live bi	come of pregnal rth 2 ☐ Fetal ant at time of de wn	death 3[⊒Ectopic p ⊒ Other (sµ						23d. Date Mont		ery Day	Year
<u>α</u>	0 0	by	Part II. Other significant con	ditions contri	buting to de	ath but not resu	ulting in the L	inderlying o	ause give	en in Part I	l.		obacco u Yes 2			he cause o	f death? ⊒Unknown
orc	w require been sig should b	etec										04- 146-		045 144		finding	a available
Records,	The law cate has by page 2 sh	Completed						·				24a. Was autor perfo		pride	ior to co eath?	mpletion o	s available cause of
Vital	sicien: certifica irector, p	Be	25. Was case referred to me examiner?	dical						26. Place	e of Death	(Check only o	ne)				
f <	S 0	To E	1 ☐ Yes 2X No	Hos	ipital: 1 □ Ir	npatient 2 🗆	ER/Outpatie	nt 3 D	OA Oth	er: 4 🗆 Nı	ursing Ho	ne 5🏿 Resid	dence	6 Other	(Specif	(y)	
o uc			27. Manner of Death 1 🛣 Natural 5 🗆 Pe		28a. Date o (Montl	f Injury n, Day Year)	28b. Time o Injury	of M	28c. Injun Worl	yat k? Yes 2□		28d. Describe I	how injur	y occurre	d		
Division	To the Hospitel or Attending within 24 hours efter death. To the Funerel Director: After completely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Co	estigation uld not be termined	28e. Place buildin	of Injury - At ho	me, farm, st					28f. Location (S City or Tox			r or Rura	al Route N	ım <i>ber</i> ,
	e Hospitel 24 hours e e Funerei D letely filled i		29a. Certifier 1 🔀 Certifier (Check only 2 Med	ifying Physic	ian: To the	best of my knows	wledge, dea	th occurred	at the tin	ne, date ar	nd place, a	and due to the	cause(s)	and man	ner as s	stated.	e(s)
	To the H within 24 To the Fi complete	Aedicai	one)	1 0	and mann					e number		4				Day, Year	
	To Too	Σ	29b. Signature and title of ce	TX						-	7:						
	5			1/	_ \				U S	26	27)	Oct	ober	12,	2004	<u> </u>
			30. Name and address of per								0.7		0000				
			Joseph Kapl			3111 Pr		hilip	Dri	ve,	Olney	7, MD 2	0832				
	St Regist	ate rar	31. Date filed (Month, Day, 1)	3 2004	32. 0	egistrar's Signa	ture	Spo	uks	/							

			1 - State of Maryland / Department Certificate State of Maryland / Department	t of Health and Me of Death		2004	34159
	Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al.	Georgia Jean Kreigline 4a. Facility Name (If not institution, give street and number) 4b. City, T	Town, or Location of Death	ctober 1	1 2004 4c. County of Death	5:10 P M
	Examin	ęr		rederick		Frederick	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under	1 Year If Under 24 Hrs. 8	Date of Birth	9 Rintho	place (State or Foreign
Ш	Director		213-30-0491 10 W 2X 1 00 Yrs.		(Month, Day, Young, 2I,	1938 Vir	ginia
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			1	0d. Inside City Limits
	Maryl f sho	to	MD Carroll Mt. Airy				1 ☐ Yes 2 ☐ No
	r 28e	Irec	10e. Street and Number 10f. Zip (Code	10g	. Citizen of What Cour	
	th wit	alD	7827 East Hill Road 217	771		USA	
Maryland 21215-0036	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event. The Medical Examinal must be ricitlised at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes, specific for a point of the following for a point o	ent of Hispanic Origin? (Specifify Cuban, Mexican, Puerto Rid	fy Yes or No- can, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
2-0	72 hc natur	eted	15. Decedent's Education 16a. Decedent's Usual (Specify only highest grade completed) (Give kind of work	l Occupation k done during most of working e retired)	16	b. Kind of Business/Inc	dustry
121	within ne.	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Cooks He1			modes Hama	
0 0	filled v Hygie Ither t		17. Father's Name (First, Middle, Last)	18. Mother's Name (F		ırsing Home idən Sumamə)	}
lan	id be lental ked o ic eve	To Be	Roy Sharitz	Virginia			
ary	shou and M s mar		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address	(Street and Number or Rural F	Route Number, C	ity or Town, State, Zip	Code)
	and 2 eaith m 27 ner tre			ldstown Road			
altimore,	bages 1 ent of H ht: If iter y or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	her place) Cematory 10/13		c. Location - City or To agerstown ,	
Baltin	permit. F Departm Importar any injut			1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		iams Funer	
	40280		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode		swick, M		Approximate
	Physician		shock, or heart failure. List only one cause on each line.	PEST	ospitatory arrest,		Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):		A1===0		
	Examiner	_	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	d BSTRUCTIVE	DUSEN	JE MI	but yoars
	nsit	nine	cause. Enter Underlying Cause (Disease or injury				
á	icate be executed physician and s the burial-transit	Examine	that initiated events c. The second of the				
8760,	ate be hysicia	Physician/Medical	d				
9	ding p	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy				
Box	eath certific attending p	clan	in the past 12 months?			23d. Date of delive Month	ory Day Year
P.O.	t the d by the ached	hysl	1 ☐ Yes 2 No 9 ☐ Unknown 9 ☐ Unknown				
	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transi	by	Part II. Other significant conditions contributing to death but not resulting in the underlying ca	use given in Part I.	23e. Did tobac	co use contribute to the	ne cause of death?
Division of Vital Records,	w requir been si should	Completed			24a. Was an	24b. Were autor	psy findings available
Re	The lav	omp			autopsy performed 1 Yes 2	prior to con	npletion of cause of
ital		BeC	25. Was case referred to medical examiner?	26. Place of Death (C		(140	2010
of <	Physicien: r this certific ral director,	To E	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DO/		5 Residence	e 6 □ Other (Specify	")
o uc	ling P	iuo :	M. M. M. M. M. M. M. M. M. M. M. M. M. M	Work?	d. Describe how i	injury occurred	
isio	Attending r death. sctor: After	ficat	3 Suicide 6 Could not be	1 ☐ Yes 2 ☐ No	f. Location (Stree	t and Number or Rura	l Route Number.
Ω	al or A s after if Dire	Certification:	4 Homicide determined determined building, etc. (Specify)	und ===	City or Town, S		, reals raines,
	To the Hospital or Attending Physiclen: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred a 2 Medicel Examiner: On the basis of examination and/or investigation, and manner stated.	it the time, date and place, and in my opinion, death occurred	d due to the caus at the time, date	e(s) and manner as stand place, and due to	ated. the cause(s)
_	To the within 2. To the I complet	Me	29b. Signature and title of certifier	License number		OCT . 12,	
7			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				
			C. Mught Day Karl 32 Basisted Signature	Sparks	21716	A	
4	Sta Registr		31. Date filed (Month, Day Xear) 1 4 2004 Signature	Sparks			

				1 - For State Registrar	State	of Mary	rland / [Depa <i>Cer</i>	rtment of l	Health and M Death		gier 2 () (14	34160
		0 0	H	1. Decedent's Name (First, Middle, La	ast)		77.				2. Date of De	ath		3. Time of Death
		Physici /Medi		Upshur Lowno	les, J	r.					oct.	21, 200	$\frac{4}{4}$	6:30 A M
	1	Examir	ner	4a. Facility Name (If not institution, gi HOSPICE OF Ba at Gilchrist	ltimo: Cente	u <i>mber)</i> re r			4b. City, Town, o	or Location of Death		4c. County Balt		
·		Funeral Director			Sex 1AM 2□F		yrs. last birt	thday) Yrs.	If Under 1 Year Months Days		8. Date of Bir (Month, Da March	19, 1947	9. Birth Cou Ma	place (State or Foreign intry) ryland
4		and		Usual Residence of Decedent 10a. State 10b. County		10	c. City, Town	ortoc	ation					10d Incide City Limits
		death with the Maryland ms 23e or 28e-f ahow rmust be notified at	lor	MD Baltin	nore		Parl							10d. Inside City Limits 1 ☐ Yes 2 No
		r 28e	rect	10e. Street and Number					10f. Zip Code			10g. Citizen of	What Cou	intry?
		th witi	alD	2420 Bond Roa	ıd				2112	20		U.S	.A.	•
_		tems	Funeral Director	11. Marital Status	12. Was Dec Amed F	cedent Ever	in U.S.	13. W	as Decedent of F Yes, specify Cub	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No Rican, etc.)		e - Amer	ican Indian,
AM	36	rs afte	by Fi	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	1 🕅 Yes If Yes, G	2□No ive Dates:Vi€	etnam	i	□ Yes 2X No	Specify:	,		. Wh	
4	21215-0036	2 hou atura		15. Decedent's E	ducation		16a.	Decede	ent's Usual Occup	pation		16b, Kind of B	usiness/li	ndustry
8	215	thin 7 le.	Completed	(Specify only highest gr Elementary/Secondary (0-12)) (1-4or 5+)	_	(Give k	ind of work done O NOT use retire	during most of worki d)	ing			
	121	led wi lygien har th		12			_ La	abo	rer					ighways
7	Maryland	2 should be filed within 72 hours after dea and Mental Hygiene. Is marked othar then "natural", or flems: aumatic evant, the Matical Examinat m	Be c	17. Father's Name (First, Middle, Las. Upshur Lownde						18. Mother's Name Emily I			*	
(8)	Z	shoule nd Me mark	T _o	19a. Informant's Name/Relationship			19b.	Mailing	Address (Street	and Number or Rura				p Code)
\cup		s 1 and 2 if Health are item 27 la other trau		Jan E. Lowndes						Rd., Parl	kton,			0 0000)
7	Baltimore,	of He of He II item		20a. Method of Disposition 1 ☐ Burial 2 【★Cremation 3 [Removal from	State 2	0b. Place of cemeter	Dispos	ition (Name of atory or other place DWNE	oe Oct.	22.	20c. Location -	City or T	own, State
8	ij	Pag tment tant: jury c		'4 □ Donation 5 □ Other (Spaci	fy)	Otato	Crema	tlor	n Servic	e 2004	1 '	York	•	
have '	Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Ia marked othar then "natural", or Items 23e or 28e-f ahow any injury or othar traumatic evant, the Mcdical Examinar must be notified at once.		21. Signature / Fun-fall Service Line	tenst	xii		_ Z 4	secon	tenstein d St., N	Morti	eaom,	Inc. PA	17349
3				23a. Part1. Enter the disease, or conspock, or heart failure. List only	one cause on	each line.		200				rest,		Approximate Interval Between
		Physician / /Medical		Immediate Cause (Final dise se or condition resulting in death)	a M	cta.	>TAS	R	- Mer	mone	7			Onset and Death
4		Examiner			Due to	(or as a co	nsequence o	of):						
Detober			Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b Due to	(or as a co	nsequence o	ıf):						
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00	Вох 6	leath certifi attending i for use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome of pr	egnancy					23d Dat	e of deliv	0.00
9		death certi e attending sd for use a	Physician/M	in the past 12 months?	4☐ Pregi	nant at time	Fetal death of death		ctopic pregnancy Other (s <i>pecify)</i>			Moi		Day Year
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wind		w requires that the de been signed by the should be detached	by	Part II. Other significant conditions	contributing to d	leath but no	t resulting in	the unc	lerlying cause giv	en in Part I.				he cause of death?
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2		Phyaiclan; The this certificate har all director, page	0 B	examiner?	Hospital:	Inpatient	2 ER/Out	natient	3□ DOA Oth	26. Place of Death er: 4 \sum Nursing Hom			r /Casad	Moseige
Shir	o u	F = E	T: uc	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date		28b. Ti		28c. Injury Worl			ow injury occurr	1-7	7,000
00	Siol	eath. or: Af the fu	catlc	2 Accident investigatio	n	,,		Joriy		Yes 2 □ No				
3	Division	or Att	Certification:	3 Suicide 6 Could not be determined	289. Place	of Injury ing, etc. (S	At home, farr <i>becify)</i>	m, stree	t, factory, office	2	8f. Location (S City or Tow	treet and Numbe n, State)	or Or Rura	I Route Number,
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		To the Hospital or Attending within 24 hours after death. To the Funaral Director: Attercompletely filled in by the funer	edical	(Check only 2 Medical Examone)	niner: On the b	asis of examener stated.	mination and	or inve	stigation, in my o	pinion, death occurre	d at the time, o	late and place, a	nd due to	the cause(s)
		To the To the comp	Me	29b. Signature and title of certifier	5				29c. License	number	2	9d. Date signed	(Month,	Day, Year)
	•			Allan	curs				25	8303	C	CFOBEL	21	2004
		0		30. Name and address of person who	completed caus	se of death	(Item 23a) (T	уре, Рг	int) ([Les St	Rall	croser	10	2 12000
		Sta	te	31. Date filed (Month, Day, Year)	32. F	Regional	e ature	1 7			Do Wil	VIVARE N	000	1004
		Registr		OCT 2 7	2004	Sener	in	B	Lan.	100				

34161 State of Maryland / Department of Health and Mental Hygie 10 0 4

			1 - State Registrar 1. Decedent's Name (First, Middle, Last)	061	tificate of De	atri	2. Date of Dea Month		Year	3. Time of Death
	Physici /Medio		ORLANDO CLIFTON LAWRENCE				Oct.	14, 20		0530 AM
	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Loc	cation of Death		4c. County of		
			207 Graham Avenue	to a biat do A	Berlin If Under 1 Year If	Under 24 Hrs.	8. Date of Birth	Worc		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs 227–20–3581 7. Age (In yrs 21 F 7. Age (In yrs 227 F 7. Age (In y	78 Yrs.		lours Min.	11/28/1	925	Virg	tace (State or Foreign try) inia
	anyland show	۲		ity, Town or Lo	cation				1	0d. Inside City Limits 1 ☐¥es 2 ☐ No
	28a-f	Director	MD Worcester Be	erlin	10f. Zip Code	-		10g. Citizen of W	hat Coun	ntry?
	with with the or :	급			21811				SA	,
	ms 23	Funeral	207 Graham Avenue 11. Marital Status 12. Was Decedent Ever in U	J.S. 13.	Was Decedent of Hispa f Yes, specify Cuban, N	nic Origin? (Spe	ecify Yes or No-			an Indian,
36	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other then "natural", or items 23e or 28s-f show imatic event, it a Medical Examirar must be rutified at	by Fur	Armed Forces? 1 Never Married 2 Married Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: WW.			ресіту:	ricari, etc.)	Specify:		
Maryland 21215-0036	72 hot natura	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupation kind of work done during	n ng most of worki	ing	16b. Kind of Bus	iness/Inc	dustry
7	filed within 72 Hygiene. other then "nai ant, the Medic	nple	Elementary/Secondary (0-12) College (1-4or 5+)	life.	DO NOT use retired)			Gas Di	etri	hutor
2	lled w tygier her th		17. Father's Name (First, Middle, Last)	Serv	ice Manager		(First, Middle,	Maiden Sumame		DUCOL
anc	ould be fill Mental Hy wrked oth	Be c	Walter Lawrence			Melvina			•	
2	should nd Men r marke umatic	2	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and	Number or Rura	al Route Numbe	r, City or Town, S	State, Zip	Code)
	1 and 2 s Health ar em 27 ls other trau		Nellie Lawrence (wife)	207 G	raham Ave.	, Berlin	n, MD 21	1811		
Jre,	as 1 a			Ptace of Dispo cemetery, crer	sition (Name of matory or other place)	C	Date	20c. Location - 0	City or To	wn, State
Ĕ	Pages ment of ant: If it ury or o		'4 Donation 5 Other (Specify)		st Cemetery	10/17/		Pocomoke	e Cit	ty, MD
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 Is marke any injury or other traumatic ODGs.		21. Signature of Functal Service Licensee	HC	Name and Address of Lloway Mels	Facility Son Fund	eral Hon	ne, P.A.	218	51
· Y			23a. Part1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each tine.	ath. Do not ent	3 Linden Aver the mode of dying, su	uch as cardiac o	or respiratory ari	rest,	210	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		ell Lui		ance			Onset and Death
	/Medical		resulting in death) Due to (or as a conse)				
Sign COX	Examiner		Sequentially list conditions, bb.							
	ed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	quence or):						
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687	ifficate be executed g physicien and as the burial-transit	edical	0.							
ŏ		In/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fe		Ectopic pregnancy			23d. Date Mon		ory Day Year
. B	e deat	sicis	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of		Other (specify)			IVIOII	(4)	Day 16a1
<u>Р</u>	The law requires that the death cer ate has been signed by the attendir page 2 should be detached for use	by Physician/N	9 Unknown Part II. Other significant conditions contributing to death but not re	esutting in the u	nderlying cause given in	Part I	23e. Did to	bacco use contri	bute to th	ne cause of death?
ds,	w requires that been signed I should be det		Parti. Other significant outside controlling to country of				1 🗆 Y	es 2□No	3 🗌 Prob	ably 4 Dunknown
Records,	v requ	Completed					24a. Was a	an 24b. W	ere auto	psy findings available
Re	he lav	dmo					autop	sy pr med? de	or to cor	npletion of cause of
Vita		0	25. Was case referred to medicat		26	. Place of Death	1 ☐ Yes	7	Yes	2□ No
	ysicia s cert direct	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2	☐ ER/Outpatier	Other	4 ☐ Nursing Ho		ence 6 Othe	r (Specify	<i>y</i>)
0	g Phys ter this neral di	n:	27. Manner of Death 1 Matural 5 Pending (Month, Day Year)	28b. Time o	28c. Injury at Work?		28d. Describe h	ow intury occurre	d	
Sign	Attending Physician: r death. ector: After this certific by the funeral director,	atlo	2 Accident investigation			2 🗆 No				
Division of	frer de l'inect	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At building, etc. (Special Could not be determined 28e. Place of Injury - At building, etc. (Special Could not be determined 28e. Place of Injury - At building, etc. (Special Could not be determined 28e.)	home, farm, str cify)	eet, factory, office		28f. Location (S City or Tow	itreet and Numbe n, State)	r or Rura	l Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier Certifying Physician: To the best of my kr	nowledge, deat	h occurred at the time, o	date and place,	and due to the d	ause(s) and man	ner as st	ated.
	• Hospite 124 hours • Funerell letely filled	Medical	(Check only 2 Medical Examiner: On the basis of examinone) and manner stated.	nation and/or in	vestigation, in my opinio	on, death occurr	ed at the time, o	date and place, a	nd due to	the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. License nu			29d. Date signed		
			* XMM D. SAGE	~	029	70	2	1000	tohe	u 2004
,			30. Name and address of person who completed cause of death (Ite	em 23a) (Type,	Print)		+	5/11-		, MD
-	H.(ot)		31. Date filed (Month, Day, Year) 32. Registrar's Sign	145	E, Carr	011)	(, (1011510	UYY	MI)
	St. Regist	ate	OCT I 5 2004 Access	B 4	nach				,	

Registrar

			1 - For State Registrar	State o	f Marylar		artment of I tificate of		nd Ment		2004	34162
	Physici /Medi		Decedent's Name (First, Middle, DORIS	Last)	LE <i>P</i>	СН			M	ate of Death onth TOBER	9, 2004 Year	3. Time of Death 8:59 P M
	Examir		4a. Facility Name (If not institution, MONTGOMERY GENE				4b. City, Town, o				4c. County of De	eath
	Funeral Director		5. Social Security Number 273 22 6480	. Sex 1 □ M 2 X F	7. Age (In yrs. 78	last birthday) Yrs.	If Under 1 Year Months Days		4 Hrs. 8. Da Min. FE	ate of Birth fonth, Day, Y B.20,1	100	Birthplace (State or Foreign Country) NNSYLVANIA
	ryland how		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation					10d. Inside City Limits
	r 28a-f s	rector	MD. MONTG	OMERY		SILVE	R SPRING			100	. Citizen of What (1 Yes 2 No
	sath with	erai D	14400 HOMECREST		103		2090				NITED STA	
980	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-f show than "natural", or items 21s on 28s-f show the Maryleal Examinal must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marrie 3 □ Widowed 4 ★ Divorced	Armed Fo	2 No	- 61	Vas Decedent of H Yes, specify Cub	lispanic Origii an, Mexican, I Specify:	in? (Specify Y Puerto Rican,	es or No- etc.)	Black, Wi	nerican Indian, hite, etc. WHITE
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Marical Examinat must be notified at once.	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		1-4or 5+)	(Give	ent's Usual Occup kind of work done OO NOT use retire	during most o d)	of working	16	DAY CAR	·
	I be filed ntal Hyg ed other: event,	Be	17. Father's Name (First, Middle, La					18. Mother's			iden Sumame)	-
Maryland	2 should and Me is mark eumatic	2	CLARENCE DIEN 19a. Informant's Name/Relationship	(Type, Print)				and Number			City or Town, State	
	is 1 and of Health item 27 other tr		20a. Method of Disposition	DAUGHTER		Place of Dispos			JRT, BRO		LE, MD.	
Baltimore,	it. Page intment contents in interver		1 Burial 2 □ Cremation 3 '4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lie	cify)	State	RBECK M	IEMORIAL	PARK 1	0/13/0	4 01	NEY, MAR	RYLAND
Ba	perm Depa Impo any i		Doingum V	V. B.	cher	, M	Name and Addre	BARBE	R FUNE	RAL HO	OME 2	20882
	Physician		23a. Part1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final	ny one cause on e	acri line.						Ę, MU.	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	W	いたに (or as a consec		etive pul	M3 HA KU	1 17156	RSC		1 YEARS
	D #	iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	b. Due to	or as a nonsec	wance of):						
o,	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	or as a conseq	uence of):						
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P.O. Box	Physicien: The law requires that the death certificate has been signed by the attending I rithis certificate has been signed by the attending I ral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	1☐Live b	come of pregna irth 2 Feta ant at time of down	Ideath 3□	Ectopic pregnancy Other <i>(specify)</i>				23d. Date of de Month	elivery Day Year
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Division of Vital	nding Physicien: ath. r: After this certifica e funeral director, p	To B	examiner? 1 ☐ Yes 2 No 27. Manner of Death 1 ☐ Vatural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date (Mont		ER/Outpatient 28b. Time of Injury	28c. Injun World	^{er:} 4 □ Nursi ⁄at	28d. De	Residenc	e 6 Other (Spa	ecify)
DIVIS	al or Attendii s after death. I Director: A d in by the fu	Certification;	3 Suicide 6 Could not 4 Homicide determine	28e. Place	of Injury - At he	ome, farm, stre	et, factory, office		28f. Loc Cit	cation (Stree y or Town, S	t and Number or F tate)	Rural Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical C	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	aminer: On the ba	best of my kno asis of examina ner stated.	wledge, death tion and/or inv	occurred at the tin	ne, date and p pinion, death	place, and due occurred at th	to the caus le time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
	To the withing To the comp	Me	29b. Signature and title of certifier	14			29c. Licenso				Date signed (Mon	
	7		30. Name and address of person wh	o completed caus	e of death (Iten						103ER 9	
	Sta	te	カス・41 多いうと HE) N. 2。 31. Date filed (Month, Day, Year)	32, R	egistrar's Signa	ture	A	-	# 515,	MHEB	TON, MO	20302
	Registr		OCT 13 20	104 5	merica	9	Sports	1				

State of Maryland / Department of Health and Mental Hygie 🔑 🛭 👢 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** OCTOBER 7, 2004 ear 6:12 P M Young 0k/Medical Lee 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GEORGIA AVE & ROSMOOR BLVD SILVER SPRING MONTGOMERY CO If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 1 ☐ M 2 🖼 F Director 035 54 7139 June 10 1953 | Seoul, Korea Usual Residence of Decedent with the Maryland works ! 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, It a Madical Examiner must be putified at once. 1 ☐ Yes 2 ☐ No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 445 University Blvd. # 310 Funeral 20906 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Yes, Give 1 Never Married 2 Married 1 TYes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced Specify: Asian Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nam Lee 2 Yong 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dal S. Hong / Brother in law 2311 Norbeck Road Silver Spring, Maryland 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Demoval from State
4 Donation 5 Other (Sp) city) Gate of Heaven Cemetery 10/12/04 Silver Spring, Maryland 21. Signature of Funeral Cervice Lice 22. Name and Address of FacilityHines Rinaldi Funeral Home 11800 New Hampshire Ave Silver Spring, MD 20904 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line 1. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (uisease or injury that initiated events Examiner Due to (or as a consequence of) ng physician and as the burial-transit or Attending Physicien: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 Other (specify) 4 Pregnant at time of death ed by the a detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by sign 2 No 1 Tes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of prior to completion death? Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl. one) 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) SCENE 2 1 X Yes 2 ☐ No 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 □Natural 5 Pending 28 death. investigation 25 Accident 04 after death Director; 6 Could not be determined 3 Suicide lac- of Injury - At home, farm, street, factory, office building, etc. is pecify) 4 THomicide -SIREC within 24 hours a To the Funerel I completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causes and Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and manner states. 29a. Certifier Medical onel and manner stated. 29b. Sign ture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME OCTOBER 8, 2004 who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

Registrar

31. Date filed (Month, Day, Year)

3 2004

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie 20 14 1 - For State Registrar Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 1040 october 2004 /Medical 4c. County of Deeth 4b. City. 4a. Facility Name (If not institution, give street and number, Examiner Pital 405 altimore Johns If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | June | 10, 1917 7. Age (In yrs. last birthday) 87 Yrs. 9. Birthplece (State or Foreign **Funeral** 223-13-7921 1**X** M 2 ☐ F China Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Itam 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic avant, the Medical Examinar must be notified at 1 TYes 2 □ No Maryland Montgomery Silver Spring Director 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number 2800 Lemar St. 20904 USA Pages 1 and 2 should be filed within 72 hours after death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Asian Baltimore, Maryland 21215-0036 by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 Yr. (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Itam 27 Is marked other than ' Elementary/Secondary (0-12) Chef Culinary 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Choi Chang Chun Sang Liang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Boa Liang- Son 2800 Lemar St. Silver Spring, MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State
'4 □ Donation 5 □ Other (Specify) Parklawn Mem. Park 10/12/2004 Rockville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Ave. Silver Spring, MD 20904 Rady 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or leach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician 16/58/855 resulting in death) /Medical Due to (or as a consequence of): Examiner steesafcome Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner The law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE use 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Fetel death in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) After t Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hin 24 hours a Certifying Physician: To the best of my imowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier j 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 Michael. Nie K k mo

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)
OCT 13

2004

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 34165 = For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) October 13, 2004 **Physician** BEATRICE LEE 12:15 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 746 Farmington Road West Accokeek Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
OCT 7 1913 Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Months 1 □ M Yrs. 409-07-2611 Tennessee Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County er than "natural", or itams 23a or 28a-f show the Medical Exactinat must be notified at 1 XYes 2 ☐ No Prince George's Accokeek Maryland | 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20607 746 Farmington Road West USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No Specify: Yes Give þ 3 X Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary US Government and Mental Hygie 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be Health and Mental permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked any injury or other traumatic events. Alvis Hembree Mary Lowe Hembree ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert E. Lee Jr (Son) 3124 Eutaw Drive Waldorf, Maryland 20603 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Trinity Memorial Gardens 10-16-04 Waldorf, MD 21. Signature of Fyseral Service 22. Name and Address of Facility Eberwein Funeral Services 4433 White Pls. La. White Pls., MD 20695 M00173 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Leionyosarcoma 7 months **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a euresquanes of): Examiner The law requires that the death certificate be executed and burial-tran resulting in death) Last Due to (or as a consequence of) attending physician by Physiclan/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year į 4 Pregnant at time of death 5 Other (specify) detached eų. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? peudis Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρę 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed been 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 1□ Yes 2X No certificate completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Medical Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific

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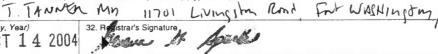
31. Date filed (Month, Day, Year)

OCT 1 4 2004

William

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Registrar

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AALE: /as decedent pre			utcome of pregr		□Ectopic pregnancy	· · · · · · · · · · · · · · · · · · ·		23d. Date of	*
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Other significan	nt conditions c	contributing to	death but not re	esulting in the t	underlying cause giv	ren in Part I.			e to the cause of death?
							1 □ Ye	s 21 21 % o 3□	Probably 4 Unknow
							24a. Was a autops perform	y prior death	
is case referred t	to medical					26 Place of Dea	th (Check only on	-	2 110
aminer?]Yes 2 □ No		Hospital:	Inpatient 2	☐ ER/Outpatie	ent 3 DOA Oth	or		nce 6 XOther (S	Specify) At Scen
nner of Death	5 Pending	28a. Date (Mo.	e of Injury	28b. Time o	of 28c. Injur Wor	y at rk?			pocity) FIE DOOL
	_	28e. Plac	ce of Injury - At Iding, etc. (Spec	home, farm, st					Rural Route Number,
		miner: On the	basis of examin						
	a of parities		The state of the s		29c. Licens	e number	2	d. Date signed (Mo	onth, Day, Year)
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Registrar DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygien 2004

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K	PD	•	State Registrar		Ce	ertificate of	Death		Reg. No.	34107			
	DI. °-:-:	· de	Decedent's Name (First, Middle, La	st)				2. Date of De	ath	3. Time of Death			
	Physici /Medic		TIM NELSON MA	RBLE, SR.				Octobe		0355 А м			
	Examin		4a. Facility Name (If not institution, giv 1575 Tilco Drive			Frederi			4c. County of Death Frederick				
	Funeral Director		5. Social Security Number 6. S 218-56-7256 Usual Residence of Decedent	Sex 7. Ag	e (In yrs. last birthda 50 Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da)EC . 7,	y, Year) Cou	nplace (State or Foreign untry) INGTON, DC			
	Maryland -f show	tor	10a. State 10b. County	INGTON	10c. City, Town or		KEEDYSVILL	E		10d. Inside City Limits 1 ☐ Yes 2 💆 No			
	th the or 28s	lrec	10e. Street and Number			10f. Zip Code			10g. Citizen of What Cou	intry?			
	23a c	ral	4416 CHESTNUT GRO				21756			S.A.			
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:		. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2X No	Hispanic Origin? (Spec an, Mexican, Puerto R Specify:	oify Yes or No lican, etc.)	14. Race - Amer Black, White Specify:				
9	2 hou	ted	15. Decedent's E (Specify only highest gr	ducation	16a. Dec	edent's Usual Occur	pation during most of working	a	16b. Kind of Business/I				
21215-0036	e filed within 7 al Hygiene. I other then "r vent, the Med	Completed	Elementary/Secondary (0-12)	College (1-4or	life	OWNER/OP	ed)		CONVENIENCE	STORE			
Maryland	ould be filed Mental Hygi arked other atic event.	To Be (17. Father's Name (First, Middle, Last ERNEST FRANKLIN M		,		18. Mother's Name OLIVE JU						
Mar	2 shoul and Mo Is marl raumati		19a. Informant's Name/Relationship (***					er, City or Town, State, Z				
	1 and 2 Health tem 27		SUSIE MARBLE, SPO	OSE	20b. Place of Dis	position (Name of	Da	AD, KE	EDYSVILLE, 1 20c. Location - City or 1				
nor	Pages nent of h int: If Its iry or o		1 ☐ Burial 2 X Cremation 3 ☐ 3 ☐ Other (Speci			ematory or other pla RG CREMAT	ORY 10/18/	2004	SMITHSBURG	. MARYLAND			
Baltimore,	그 된 번 등 .		21. Signature of Puneral Service IS e	-		22. Name and Addre			OLD NATIONA				
Ö	permi Depa Impo any ii		Kerly A. Zin	merman	•	BAST FU	NERAL HOME	BOON	SBORO, MARY	LAND 21713			
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that cause one cause on each l	d the death. Do not e ine.	nter the mode of dyi	ing, such as cardiac or	respiratory a	rrest,	Approximate Interval Between Onset and Death			
	/Medical Examiner	Iner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):	HE1105 CLET	OUC CV MILL) V 137 (TC)	MDD DISEAS				
68760,	certificate be executed uding physician and use as the burial-transit	Medical Examin	Cause (Disease or injury that initiated avents resulting in death) Last	c. Due to (or as	a consequence of):								
.O. Box 6	it the death certific by the attending p tached for use as:	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	☐ Ectopic pregnand ☐ Other (specify)	sy		23d. Date of delik Month	very Day Year			
₽	de de	by	Part II. Other significant conditions	contributing to death t	out not resulting in the	underlying cause gi	ven in Part I.		obacco use contribute to Yes 2 No 3 Pro	the cause of death?			
Vital Records,	sician; The law requires that the death certificate has been signed by the atter rector, page 2 should be detached for u	Completed						24a. Was autor perfo	an 24b. Were aut prior to commed? death?	opsy findings available ompletion of cause of			
ital		BeC	25. Was case referred to medical examiner?				26. Place of Death						
4	<u>≥</u> = 2	2	1 X Yes 2 □ No		ent 2 ER/Outpat	Brit 3 DOA	the state of the s		dence 6X Other (Spec	ify) At Scene			
ion c	tending Pasth. tor: After the funera	atlon:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigated	28a. Date of Inju (Month, Da	ury 28b. Time ay Year) Injury	Wo	nyat 21 ork?]Yes 2 □No	8d. Describe i	how injury occurred				
Division	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funera	Certification	3 Suicide 6 Could not 1 4 Homicide determined	a Z8e. Flace of In	jury - At home, farm, tc. (Specify)	street, factory, office	2	8f. Location (City or Tou	Street and Number or Rui wn, State)	al Route Number,			
	To the Hospi within 24 hour To the Funer completely fill	Medical			of examination and/or				cause(s) and manner as date and place, and due				
		Σ	29b. Signature and title of certifier	bre Yhell	Lup	O.C.N	se number		29d. Date signed (Month) October 16,				
4	HIDE		MANGSMAN	completed cause of	J. W.	111 Penn	Street, Ba	ltimor	e, Maryland	21201			
	St Regist		31. Date filed (Month, Day, Year) OCT 18	2004 32. Regist	rar's Signature	Sperile				,			

		•	For State (of Maryland / Depa Cea	artment of H			ene 0 0	14	34168
			Decedent's Name (First, Middle, Last)				2. Date of Death			3. Time of Death
	Physicia /Medic		PAMELA CLARK MOORHEA)			OCTOBER	3 2	2004	1:45 AM M
	Examin		4a. Facility Name (If not institution, give street and no	umber)	· ·	r Location of Death	1	4c. County		
			WILLIAM HILL MANOR 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	EAST	FON If Under 24 Hrs.	9 Date of Birth		ALBOT	
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 🖫 F	80 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 1 SEPT 17	1924	9. Birting Cour	place (State or Foreign htry) INOIS
	TO		Usual Residence of Decedent			I	DELT 17	1721		INOID
	show	۰	10a. State 10b. County	10c. City, Town or Lo					1	0d. Inside City Limits 1y Yes 2 □ No
	he Ma	Director	MD TALBOT 10e. Street and Number	EA	STON 10f. Zip Code		10	g. Citizen of V	Albert Cour	
	with the or i		501 DUTCHMANS LANE			1601	109		SA	itty:
	ms 23	Funeral	11 Marital Status 12. Was Dec	cedent Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba		pecify Yes or No-	14. Rac	e - Americ	an Indian,
ထွ	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Itams 23a or 28a-f show aumatic event, If a Medical Exertifier must be notified at	Fur	If Yes G	2 🔀 No	ir Yes, specify Cuba 1 □ Yes 2120 No	sn, mexican, Puer. Specify:	o Hican, etc.)	Specify	k, White,	
9	ural',	d by	3 Widowed 4 Divorced Year or	Dates:					****	ITE
2	n 72 i	Completed	15. Decedent's Education (Specify only highest grade completed) (Give	dent's Usual Occupa kind of work done o DO NOT use retired	during most of wor	king	6b. Kind of Bu	usiness/in	dustry
212	y within	omp	Elementary/Secondary (0-12) College	(1-4or 5+)	IOMEMAKER			OWI	N HOM	Έ
9	be filed stal Hygie of other event, II	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Nan	ne (First, Middle, Ma	aiden Sumam	10)	
<u>Xa</u>	should bents marked	To	HAROLD A. CLARK				OTHY STEVI			
Maryland 21215-0036	s 1 and 2 should f Health and Men item 27 is marke othar traumatic		19a. Informant's Name/Relationship (Type, Print)				ral Route Number, (Code)
	1 and 2 Health tem 27		PAMELA P. GARDNER/DAUG 20a. Method of Disposition	20b. Place of Dispo	sition (Name of		CRAPPE, MI	Dc. Location -		wn, State
no	Pages nent of I int: If its iry or o		1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State	natory`or other plac ናር ርርፑለል ሞ	1	10-5-2004	4 STF1	VENCV	ILLE, MD
altimore,	그두유금		21. Signature of Funeral Service Licensee				N & NEWNA			
ñ	Departing Department of the part of the pa		L'osyh M. Ostronski	C. F.S.P. 21	ELLOWS, H OO S. HAR	RISON ST	EASTON,	MD 216	01	IOME FA
			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	caused the death. Do not ent each line.	er the mode of dyin-	g, such as cardiac	or respiratory arres	st,		Approximate Interval Between
-	Pnysician		Immediate Cause (Final disease or condition a.	Preumon	ia					Onset and Death 4 day 5
	/Medical Examiner		resulting in death) Due to	(or as a consequence of):						10.5
	STE N	F.	Sequentially list conditions, if any, leading to immediate b. Due to	(or as a consequence of):	\sim				-	74005
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Denent.	a					10 years.
oʻ	be executed sician and burial-transit	Еха		(or as a consequence of):						1
8760	cate be executed bhysician and the burial-transit	dlcal	d							
9 X	eath certific attending p	/Me	IF FEMALE: 23c. If yes, or	utcome of pregnancy				22d Dat	o of delive	
Box	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Me	in the past 12 months?	birth 2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			Mor	e of delive nth	Day Year
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ď.	res that the de signed by the a be detached f	by P	Part II. Dther significant conditions contributing to	death but not resulting in the u	ndertying cause give	en in Part I.	23e. Did toba	cco use contr	ibute to th	e cause of death?
ğ	w require been sig should b	ted					1 🗆 Yes	2 □1No	3 ☐ Prob	ably 4 □Unknown
Records,	ne law r has be ge 2 sh	Completed					24a. Was an autopsy	i p	rior to con	osy findings available apletion of cause of
	: The						performe 1 Yes 2 €	No 1	leath?	2□ No
Vital	sician certif	o Be	25. Was case referred to medical examiner?	Inpatient 2 ER/Outpatien	ot 3 DOA Othe		th (Check only one)	- A Florit		,
ō	Phys er this eral d	\vdash		of Injury 28b. Time of	IL 3 DOA	4 M Nursing I	ome 5 Residence 28d. Describe how			9
0	uttanding death. ctor: Afte y the fun	atlo	1 ☑ Matural 5 ☐ Pending (Mo. 2 ☐ Accident investigation	oth, Day Year) Injury		Yes 2 □ No				
Division of	of or Atta after de Diracto Jin by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place build	e of Injury - At home, farm, str ling, etc. (Specify)	eet, factory, office		28f. Location (Stree City or Town,		er or Rura	Route Number,
	ortal o									
	To the Hospital or Attanding Physician: The I within 24 hours after death. To tha Funaral Diractor: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the 2 Medical Exeminer: On the and mai	e best of my knowledge, death basis of examination and/or inv nner stated.	occurred at the time vestigation, in my or	ne, date and place, pinion, death occur	and due to the cau red at the time, date	se(s) and mai and place, a	nner as stand due to	ated. the cause(s)
	ro the vithin ro the complex	Me	29b. Signature and title of certifier		29c. License	number	29d	. Date signed	(Month, L	Day, Year)
			Nussell a.	Selven It	14425	87	0	et. it	, 23	04
			30. Name and address of person who completed cau		Print)	Part	wh 7	((n 2)		
	Sta	te		Jegistrar's Signature	1000 17	Cusion	Pri sa	1001		
	Registr		OCT 0 5 2004	egistrar's Signature						

State of Maryland / Department of Health and Mental Hygiene 34169 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Day October 8, Day **Physician** 2004 ри 2:45 Joyce Wilkerson Mack /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Silver Spring Montgomery 11523 Lovejoy Street If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 28, 1926 9. Birthplace (State or Foreign Country) West Virginia 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Min. 1 □ M 24 □ F 77 Yrs. 236-36-2678 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 10b. County 1 Yes 2 No Silver Spring Marvland Montgomery Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number r than "natural", or Itams 23a or the Wedical Examiner must be IISA 20902 11523 Lovejoy Street death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status e filed within 72 hours after at Hygiene.

A Hygiene.

other than "natural", or Ital 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygier
Imporant: if item 27 is marked other th
any Injury or other traumatic event, the Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Iva Grace Cross Clarence Orville Wilkerson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2220 Avenue of the Stars, #2106W, Los Angeles, CA 90067 Valerie Johns/ Daughter 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) October 11, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 2004 Germantown, Maryland Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, 21. Signature of Funeral Service Licenses MD 20901 23a. Part1. Enter the disease, or compile ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metastatic Colon Cancer 3 Years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Records, P.O. the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 99 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed has 1 ☐ Yes 2CXNo Division of Vital funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Inpatient 4 Nursing Home 5x Residence 6 □Other (Specify) 1 Yes 2**7** No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Hospitel or Attending Pl 24 hours after death. • Funeral Director: After the Certification: After 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral D 🄁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D18219 October 11, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1221 Mercantile Lane, LARGO, MD 20774 Stephen Staal, M.D. 31. Date filed (Month, Day, Year) 32. Segistrar's Signature State 12 2004 OCT Registrar

MERSKY

Certificate of Death

4b. City, Town, or Location of Death

ROCKVILLE

If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month Day, Year) MAR 8, 1919 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1**X** M 2□ F Yrs. 85 173-12-2740 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a. State 28a-f show the Medical Exertiners ust be notified at MARYLAND MONTGOMERY ROCKVILLE Direct 10e. Street and Number 10f. Zip Code ŏ 20852 5809 NICHOLSON LANE, #816 "naturel", or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: WWII Specify: ₽ 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) PRESIDENT permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygis Importent: If item 27 is marked other any injury or other treumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOSEPH MERSKY **EMMA** ပ 19a. Informant's Name/Relationship (Type, Print) 5809 NICHOLSON LANE, #816 HARRIET S. MERSKY, WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State JUDEAN MEMORIAL GARDEN 10/10/04 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Sonald 23a. Part 1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) Yes 2 □ No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by page 2 should be peen s Physicien: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 25 No 2 R/Outpatient 3 DOA 1 Tes 1 Inpatient Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After t Hospitel or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

3 Time of Death 2004 9:40 A M 4c. County of Death MONTGOMERY 9. Birthplace (State or Foreign PENNSYLVANIA 10d. Inside City Limits Yes 2□No 10g. Citizen of What Country? UNITED STATES 14. Race - American Indian, Black. White, etc.

WHITE

FINANCIAL SERVICE

16b. Kind of Business/Industry

ROSOFF

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Reg. No.

2. Date of Death

OCTOBER 6,

20852 ROCKVILLE, MD

20c. Location - City or Town, State

OLNEY, MARYLAND

DANZANSKY-GOLDBERG MEMORIAL CHAPELS, 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 Approximate Interval Between Onset and Death

> 23d. Date of delivery Year Month Day

> > 23e. Did tobacco use contribute to the cause of death? 4 Onknown 1 Yes 2 No 3 Probably

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9901 MEDICAL CENTER DRIVE, ROCKVILLE, MD 20850 WILLIAM DOOLEY, M.D.,

State Registra

31. Date filed (Month, Day, Year) 13 2004

For State Registrar

Physician

- /Medical

Examiner

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

MILTON

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 7:15 AM moore anie OCIOIS ZK 11 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGES DOCTORS COMMUNITY HOSPITAL LANHAM | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | SEPT. 22, 1929 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Yrs. PΑ Director 274-24-3008 75 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28e-f show must be notified at 1 Yes 2 □ No Director HYATTSVILLE MD. PRINCE GEORGES 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Itams 23a 20781 U.S.A. 4207 LONGFELLOW ST. by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 ŏ 1 ☐ Yes 2 👿 No Specify: WWII Specify: 3 Widowed 4 ☐ Divorced WHITE "netural" Completed Department of Health and Mental Hygiene. Information: If item 27 Is marked other than "neture any injury of either traumatic event, the Medical ones." 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) REGISTERED NURSE NURSING 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be 2 should be fi and Mental F Is marked of VONLOHR JANIE UNK. MORGAN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 94-378 LELEAKA ST., MILILANI, HI. 96789 MORGAN MOORE/SON Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ō 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Oct.12,2004 CHAMBERS CREMATORY RIVERDALE, MD. 22. Name and Address of Facility

CHAMBERS FUNERAL HOME & CREMATORIUM, P.A.
5801 CLEVELAND AVE., RIVERDALE, MD. 20737 21. Signature of Funeral Service Licensee Mooog1 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) espiration Pnysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine neumon.a Hospital or Attanding Physicien: The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): Box 68760, 955 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) 4☐Pregnant at time of death P.O. 1 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No certificate 1 ☐ Yes 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 28c. Injury at Work? After 5 Pending 1 Tyes 2 No investigation 2 Accident Diractor: in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical To tha 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MDD 60611 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LUCK RUAD LAW + AM, MO 8118 6000 N.S. SAMUEL 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 13 2004 Registrar

			1 - For State Registrar	State of Marylar	nd / Depa	artmen <i>rtificat</i>	t of H e of L	ealth a	and M		ieppe eg. No.	004	341	72
			1. Decedent's Name (First, Middle, Las	t)						2. Date of Dea Month	th Day	Year	3. Time o	of Death
	Physici /Medic		Maude Luven:	ia Morrisor	1					October			5:05	A M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or	Location of	of Death		4c. C	ounty of Death		
Н			Citizens Nursing		for an first of the	Fr If Under	eder	ick	24 Ura 1	0.0		Freder		
	Funeral Director		215-36-6679	7. Age (<i>In yr</i> s. □ M 2気F 94	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day) Dec. 9,	, Year)	9. Birth Cou 9 Mary	place (State ntry) land	or Foreign
	pur *		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation		-					10d. inside (City Limits
	/anyli	ö	Maryland Frederic		Frede									2 ⊠ No
	28a-	Director	10e. Street and Number	K	rrede	10f. Zip	Code			1	0g. Citize	en of What Cou	ntry?	
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	daati	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.			spanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)		. Race - Ameri	can Indian,	
٥	aftar or Ita		1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 ☐ No If Yes, Give		1 ☐ Yes :		Specify:	i, rueito	nican, etc.)		Black, White,	lack	
2-003p	ural',	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:										
<u>γ</u>	within 72 hours aftar ene. than "natural", or Ita	Completed	15. Decedent's Ed (Specify only highest grad		(Give	dent's Usua kind of wor DO NOT us	rk doné d	<i>lurina</i> most	t of worki	ng	16b. Kind	d of Business/Ir	dustry	
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ַ	be filed within 72 hours after death with the Marylan at littly little with the Marylan delity yellow. In the Westerlift of Items 23s or 28s-1 show event, the Medical Exercities into the confilled at	BeC	17. Father's Name (First, Middle, Last)		11000	омоор		18. Mothe	r's Name	(First, Middle, I				
yiand	uld by Manta Vlanta Irked	To B	Richard Naylor						Luve	nia 1	Unkno	own		
Mar	2 should ba f and Mantal H Is marked of raumatic eve		19a. Informant's Name/Relationship (7	ype, Print)		-				ul Route Number			•	
ح	and saalth m 27 har tr		Pamela Mallory	205	1032 Place of Dispo			erty		Frede		<u>-</u>		701
<u> </u>	gas I If of H If Ita		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from State	cemetery, cre	matory or o	ther place		Octo	ber 15,		ation - City or T		
altimor	it. Pa		' 4 □Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen:		sthave	n Mem 2. Name an						erick,		
g	parmit. Pagas 1 and 2 should be Daparment of Haalth and Manta Important: If Itam 27 is marked any injury or other traumatic ed once.		1000	1					DCC	auffer F ce Fred				
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O. BOX	daath a attar d for u	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of c 9 ☐ Unknown	el death 3	⊒Ectopic pr]Other (sp					23	d. Date of deliv Month	*	Year
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ecord	law raquiras as baan sign 2 should be	Completed								1 □ Ye	n	No 3 ☐ Prol 24b. Were auto	psy findings	Unknown available
r	Tha ata h page	Com								autops perform 1 Yes 2		prior to co death? 1 ☐ Yes	mpletion of a	cause of
VII	ysician: Th is cartificata diractor, pag	Be	25. Was case referred to medical examiner?	I de acidal.				3	of Death	(Check only on	ө)			
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ב	ling Afta funa	atlon	27. Manner of Death 1 Natural 5 Pending Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	M	8c. Injury Work 1 🔲 \	rate (? Yes 2 1		28d. Describe ho	w injury (occurred		
Division	To the Mospital or Attending Ph within 24 hours aftar daath. To the Funeral Director: Aftar th complataly fillad in by tha funaral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, str	reet, factory	, office		2	28f. Location (St. City or Town	reet and I n, State)	Number or Rura	al Route Nun	n <i>ber</i> ,
	e Hospi 24 hou e Funer lataly fill	edical	29a. Certifier Certifying Phy (Check only Medical Exam	ysician: To the best of my kno liner: On the basis of examine and manner stated.	owledge, deat ation and/or in	h occurred vestigation,	at the tim , in my op	ie, date and pinion, deat	d place, a th occurre	and due to the ca ed at the time, da	ause(s) ar ate and p	nd manner as s lace, and due to	tated. the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	200		290	. License	number		2	9d. Date :	signed (Month,	Day, Year)	
			A stort L-	Tarm)-/	37	11		19	13/1	24	
	i		30. Name and address of person who						,					
			Robert L. Kurfma: 31. Date filed (Month, Day, Year)	nn M.D. 300 32. Registrar's Signs	W. Nir	th St	reet	Fr	eder	ick, MD	217	01		
	Sta Registi		nrt	1 / 20B4 A	Land L.	Jan Jan		hoos	1					

State of Maryland / Department of Health and Mental Hygie Pen n L AMEND ITEM #17PER FIT C837 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Edith May Miller October 12,2004 6:00A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7220 SE Crain Highway Upper Marlboro Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) | April 12,1918 | Washington DC 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1□M 2√7F 577-20-9748 86 Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f ehov the Medical Examinar must be notified at 1 ☐ Yes 2 🕅 No Maryland Prince George's Directo Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7220 SE Crain Highway 20772 U.S.A. death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours atter nent of Health and Merial Hyglene. Int: If item 27 is marked other than "natural; or the Iny or other traumatic event, the Majical Examina 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White þ 3 Nidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Waitress Hot Shoppe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JAMES F. Francis Grove Mary F. E1am ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline M. McDougall (Daughter) 7220 SE Crain Highway Upper Marlboro MD20772 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State October 15. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 2004 Clinton, Maryland 21. Signature of uneral Service Licenses 22. Name and Address of Facility Lee Funeral Home, Inc. 100153 6633 Old ALexandria Ferry Road Clinton, MD20735 620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Coronary Artery Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ ed bluods 2 XNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an has page 2 autopsy certificate 24 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral dir 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident s after death 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) M1004588 30. Name and address of person completed cause of death (Item 23a) (Type, Print) DB5 Car1 1221 Mercantile Lane Largo Maryland Johnson M.D. 31. Date filed (Month, Day, Year) gistrar's Signature State OCT 1 4 2004 Registrar

	•	•	For State Registrar	State of Maryland		artment <i>tificate</i>			nd Me		giene 10g. No.	004	3417	4
			1. Decedent's Name (First, Middle, Last)					-w-	2.	Date of Dea	ıth		3. Time of Dea	th
	Physici /Medic		JESSICA A		PER	y der	S		0	CTOBET	7 19	2004	6:30	M
	Examin		4a. Facility Name (If not institution, give st	treet and number)		4b. City,	Town, or L	ocation of	Death		4c.	County of Dea	th	
			9413 Fens Hollow				irel	1/11 1 To				oward		
	Funeral Director		5. Social Security Number 6. Sex 1 □	7. Age (In yrs. I	ast birthday) Yrs.	If Under Months	Days 14	Hours	Min.	Date of Birth (Month, Day)Ct. 5	, Year) 200	, C	thplace <i>(State or For</i> o <i>untry)</i> Maryland	eign
	po .		Usual Residence of Decedent 10a, State 10b, County	10c City	, Town or Lo	cation							10d Inside City I is	-ite
	sho	5	,			Callon							10d. Inside City Lin	
	28a-f	Director	Md. Howard 10e. Street and Number	La	urel	10f, Zip	Code				10a Citi:	zen of What C		
	with Ba or	ā	9413 Fens Hollow			101. 240		0723				ted Sta	•	
	ms 2;	era		2. Was Decedent Ever in U.	S. 13. V	Was Deced			n? (Specif	y Yes or No-		14. Race - Am		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importents: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Exama included to incitified at once.	by Funerai	1 Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		tYes,spec l⊠Yes 2		Mexican, i		an, etc.) (ican		Black. Whi	_{te, etc.} Nhite	
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215	e. an "n Med	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	kind of wor DO NOT us	k done du e retired)	ring most o	of working					
2	ed wil	Con	0	0	No	ne						one		
Maryland	ntal Hy ed oth	Be	17. Father's Name (First, Middle, Last) Dennis Joseph Pende	ers. III			1			irst, Middle, macho	Maiden .	Sumame)		
Ž	thoute d Me mark matic	٦ و	19a. Informant's Name/Relationship (Typ		19b Mailin	n Address	(Street an				r City or	Town, State,	Zin Code)	
	alth ar		Dennis J. Penders,			Fens			Laur		1d .	20723		
ore,	of Head		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	20b. PI	ace of Dispos	sition (Name	e of ther place)		Date	9	20c. Lo	cation - City or	Town, State	
<u><u>Ĕ</u></u>	Page ment ent: It ury o		'4 □Donation 5 □Other (Specify)		beck M				10/22	2/04	01	ney, Ma	ryland	
Baltimore,	permit. Departi Import any inj		21. Signature of Funeral Service Licenses	erher	M	Name and uriel	Address H. I Box	of Facility Sarbe 5038	r Fun . Lav	eral l	lome ille	. Md.	20882	
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death	not ente	er the mode			-				Approximate Interval Between	
	Physician [*]		Immediate Cause (Final disease or condition	TRISOMY	18								Onset and Death	1
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ience of):									
	-Adminier	_	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to/or as a consequ	ience of):									
	nted	Examiner	Cause (Disease of Injury	200 12:51 03 0 0013640	ierice orj.									
<u>,</u>	execu n and ial-tra	Exai	that initiated events c. resulting in death) Last	Jue to (or as a consequ	ence of);									
8760,	icate be executed physician and s the burial-transit	dical												
	ng ph	Medi	IF FEMALE:											
Вох	ath ce tendii	an/h	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal		Ectopic pre	gnancy				2	3d. Date of de Month		
o.	Attending Physicien: The law requires that the death certific rideath. **Color Atter this certificate has been signed by the attending pot the funeral director, page 2 should be detached for use as	Physician/Me	1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown	eath 5	Other (spe	ecify)					MONIT	Day Year	
σ.	that I	y Ph	Part II. Other significant conditions cont	nbuting to death but not resu	Iting in the un	nderlying ca	iuse given	in Part I.		23e. Did to	bacco us	e contribute to	the cause of death	?
Records,	w requires been sign should be	ed by				an .				1 🗆 Y	es 2	No 3□P	robably 4 Unkno	wn
000	aw requisite been 2 should	piet								24a. Wasa		24b. Were at	utopsy findings availa	ıble
ž	The lav	Completed								autops perfori		death?	completion of cause	Οī
Vital	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?				2	26. Place o	f Death (C	heck only on	-			
7	Physic this ca	ဥ	1 Yes 2 No	-	ER/Outpatien			4 🗀 Nursi	ing Home	5 Reside	ence 6	□Other (Spe	cify)	
Division of	ding Ph h. After th funeral	ion	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		3c. Injury a Work?			Describe ho	ow injury	occurred		
S	death death stor:	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho	mo farm etro	M (actor)		s 2 No		Location (St	root and	Number or D	ural Route Number,	
<u>≥</u>	el or A s after of Direct	Certification:	4 Homicide determined	building, etc. (Specify)	ei, raciory,	Onice		201.	City or Town	n, State)	IVUIDEI OI NI	irai noute ivumber,	
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edicai C	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examina	cian: To the best of my know er: On the basis of examinati and manner stated.	vledge, death ion and/or inv	occurred a restigation,	it the time, in my opin	, date and p nion, death	place, and occurred a	due to the ca at the time, d	ause(s) a ate and p	and manner as place, and due	stated. to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c.	License n	umber		2	9d. Date	signed (Mont	h, Day, Year)	
			hancydutt	mas		D	003	1000	2	C	cto.	ber 20	,2004	
			30. Name and address of verson who com			•								
			NANCY HUTTON MD	MARYLAND	comn	14117	y 40	SPICE	WH	ITEM	ARS	H, MAF	RYLAND	
	Sta Registr	te ar	31. Date filed (Month, Day, Year) OCT 2 7 200	32. Registrar's Signat	8	200	rack.							

			1 - State Registrer 1. Decedent's Name (First, Middle, Last)	State of Maryla	nd / Depa <i>Cei</i>	artment of H rtificate of L	ealth and I Death	Reg	g. No.	34175	
	Physici		Vivian Irene Papa					2. Date of Death Month Oct.	17 2004	3. Time of Death O2:45A M	
}	/Media Examir		4a. Fecility Name (If not institution, give s			4b. City, Town, or		1	4c. County of Death	1	
			Avalon Manor Heal 5. Social Security Number 6. Sex		er s. last birthday)	Hagerst	OWN If Under 24 Hrs.	O Data of Bigh	Washingto		
	Funeral Director			M 280F 89	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 1	Year) 9. Birth Con	iplace (State or Foreign untry) MD	
	and		Usual Residence of Decedent 10a. State 10b. County	100.0	ity. Town or Lo	eation			+2		
	Manyli f sho	tor	MD Washingt		Hagersto					10d. Inside City Limits 1 ☐ Yes 2X No	
	3a or 26a st be nati	i Director	10e. Street and Number 14014 Marsh Pike			10f. Zip Code	742	100	g. Citizen of What Cou US	intry?	
036	hours after death with the Maryland tural', or Items 23a or 28a-1 show al Examinar must be neitified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in the Amed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Vas Decedent of His fYes, specify Cubar I □ Yes 2⊠ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White		
215-0036	n 72	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	16a. Deced (Give life. L	lent's Usual Occupa kind of work done di DO NOT use retired)	tion uring most of work	king 16	b. Kind of Business/I	ndustry	
2	filed with Hygiene. other thar ent, Ire M	Col	17. Father's Name (First, Middle, Last)			Owner	18 Mother's Nam	ne (First, Middle, Ma	Tavern		
yland	Menta Menta arked artic ev	To Be	Charles Edward Sta				Bessie	Irene Roh	rer		
, mary	and 2 shoulealth and N m 27 is maine trauman		19a. Informant's Name/Relationship (Type Frank Papa / Son	oe, Print)					City or Town, State, Zi, $MD~21742$		
saitimore,	ges 1 it of H if ite or ot	ĺ	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State		sition (Name of natory or other place)		oc. Location - City or T		
alt	permit. Pa Departmer Important: any njury		21. Signature of Function ervice Lice ise			Name and Address			agerstown, Minnich Fu	neral Home	
	90 5 5 9		1/ayt				omac Str	eet, Hage	rstown, M		
,	Pnysician /Medical		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that the sed the dealer cause on sach line.		er the mode of dying	, such as cardiac	or respiratory arrest	t,	Approximate Interval Between Onset and Death	
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):						Years.		
,00/80	ificate be executed g physician and as the burial-transit	al Examiner								Years.	
000	tificate ng phy as the	Medical									
O. DOX	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours alterdeath. Within 24 hours alterdeath. To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Patho 9 □ Unknown	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o 9 ☐ Unknown	al death 3 🔲	Ectopic pregnancy Other (specify)			23d. Date of delive	ery Day Year	
corus, r.	equires that ten signed by ould be deta	by	Part II. Other significant conditions cond	tributing to death but not res	sulting in the un	derlying cause given	in Part I.		cco use contribute to to		
שבו	n: The law r icate has be r. page 2 sh	Completed						24a. Was an autopsy performed 1 ☐ Yes 2	d? death?	psy findings available mpletion of cause of	
=	siciar s certif irecto	o Be	25. Was case referred to medical examiner? 1 \sum Yes 2 \textstyle Yes Ho	ospital:	ER/Outpatient	Other		h (Check only one)			
5	fing Phy I. After this funeral o	\vdash	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury a Work?	4 ZNursing Ho	me 5 ☐ Residenc 28d. Describe how	e 6 Other (Specifinjury occurred	y)	
	al or Attens after deatl Director: d in by the	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, stre fy)		s 2 No	28f. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,	
	ne Hospit. n 24 hours ne Funera	Medical C	29a. Certifier 1 Certifying Physic (Check bon) 2 Medicel Examin	ician: To the best of my kno er: On the basis of examina and manner stated.	owledge, death ation and/or inve	occurred at the time estigation, in my opir	, date and place, nion, death occurr	and due to the caus ed at the time, date	e(s) and manner as si and place, and due to	ated. the cause(s)	
ŀ	To the within To the Comp	Ň	29b. Signature and title of certifier	IN MD)	29c. License	103/	29d.	Date signed (Month,	Day, Year)	
2	4-8		30. Name and address of person who con	refeted cause of death (Iter	m 23a) (Type, P	(rint) 94/4-1	18478	RSBN DO	Pe Hora	Day, Year) LCO 4. PRSTOUNMI 21742	
H	Stat	-C	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	a. N. D			WHEN.	21742	

			For State of State AMEND#29cpcrMD10/14/04, E	Maryland / De MW,McCo C	epartment of F Dertificate of a	lealth and Me <i>Death</i>	ental Hygie Reg.		34176	
	Physici	an	Decedent's Name (First, Middle, Last)				2. Date of Oeath Month	Day Year	3. Time of Death	
	/Medic Examin	al	Edna M. Purks 4a. Facility Name (If not institution, give street and number)	ber)	4b. City, Town, o	r Location of Death	October	8, 2004 4c. County of Death	4:35 ^{P M}	
	Examili	eı	Shady Grove Adventist Hos		Rockv			Montgomer	ry	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2	. Age (In yrs. last birtho	Months Days	Hours Min	8. Date of Birth (Month, Day, Ye Feb. 6, 1	ear) Cou	place (State or Foreign ntry) ington, DC	
			Usual Residence of Decedent					723 114011	ingcom, be	
	arylan show	L	10a. State 10b. County	10c. City, Town o					10d. Inside City Limits 1 ☐ Yes 2 🖾No	
	he Ma 28e-f	Directo	Maryland Montgomery 10e. Street and Number	Rockvi			100	. Citizen of What Cou		
	3e or 2		14004 Bauer Drive		10f. Zip Code 20853		Tog.	USA	nuy r	
036	be filed within 72 hours after death with the Maryland tal Hygiene. id other then "naturel", or Items 23e or 28e-f ehow event, the Mediral Examinat must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ₺ Widowed 4 □ Divorced 12. Was Deced Armed Ford 1 □ Yes 2 1f Yes, Give Year or Dat	2 X No	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No		cify Yes or No- lican, etc.)	14. Race - Ameri Black, White, Specify: Whit	etc.	
9500-9121	filed within 72 ho Hygiene. kher then "natur int, 113 Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1.2 College (1-	4or 5+)	ecedent's Usual Occup Give kind of work done fe. DO NOT use retired Homemaker	ation during most of working f)	9	16b. Kind of Business/Industry		
מ	illed Hygi other	Be Co	17. Father's Name (First, Middle, Last)		TOMOMON CT	18. Mother's Name	(First, Middle, Mai	Own Home den Sumame)	<u> </u>	
/Ian	should be nd Mental marked o	To B	Peter J. Murray			Mary De	viny			
Maryland 2	2 sho and I Is ma		19a. Informant's Name/Relationship (Type, Print)	19b. N	Mailing Address (Street	and Number or Rural	Route Number, C	ity or Town, State, Zip	Code)	
Baltimore, N	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 Is marked any injury or other treumatic evense.		Francis E. Purks, Jr./ S 20a. Method of Disposition 1 🖾 Burial 2 □ Cremation 3 □ Removal from S	20b. Place of D	04 Bauer Disposition (Name of crematory or other place) f Heaven	Octobe	er 11,	c. Location - City or To		
	artmer ortent injury		* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Ceme	etery	ss of Facility			ng, Maryland	
Ba	Depril Impo		1 2 3		22. Name and Addre Francis J. 500 Univers	Collins F sity BLvd,	uneral H W, Silv	ôme Inc. er Spring,	MD 20901	
			23a. Part1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ea			g, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death	
1	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	eriton						
	Examiner		Due to (o	ras a consequence of)	1					
		ner	Sequentially list conditions, if any, leading to immediate Due to (o	r as a consequence of)	:					
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60,	ficate be executed g physician and as the burial-transit		Due to (o	r as a consequence or).	•		7	3		
68760		edicai	d							
O. Box	ne death certific the attending p thed for use as	Physician/M	in the past 12 months	ome of pregnancy th 2 Fetal death nt at time of death vn	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	· · · · · · · · · · · · · · · · · · ·		23d. Date of delive Month	ery Day Year	
s,	The law requires that the de tte has been signed by the a bage 2 should be detached f	by Ph	Part II. Other significant conditions contributing to dea	th but not resulting in th	ne underlying cause giv	en in Part I.		co use contribute to the		
ord	w require been si should b	eted	Malnutation					2 THO 3 □ Prot		
Vital Records,		Completed					24a. Was an autopsy performed	prior to co death?	psy findings available mpletion of cause of	
Z E	Physicien: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 1	patient 2 ER/Outpa	ationt 3CT DOA Oth	26. Place of Death		- 0 Flott - (0 - 1)		
Jivision of	ding Phy. h. A ter this funeral d	H .	27. Manner eath 1 tural 5 Pending 28a. Date of (Month)		ne of 28c. Injury	y at 28	e 5	e 6 Other (Specilinjury occurred	y)	
DIVISI	or Atten after deat Director: in by the	Certification:	3 Suicide 6 Could not be	of Injury - At home, farm g, etc. (Specify)			Bf. Location (Stree City or Town, S	t and Number or Rura tate)	al Route Number,	
	To the Hospitel within 24 hours To the Funerel completely filled	edicai	29a. Certifier (Check only onle) 1 Certifying Physician: To the bar and manner: On the bar and manner:	sis of examination and/o	death occurred at the tin or investigation, in my o	ne, date and place, ar pinion, death occurred	nd due to the caus of at the time, date	e(s) and manner as s and place, and due to	tated. the cause(s)	
)	Tot withi	W	29b. Signature and title of certifier	, M	29c. Licens DOC	054068 354068	29d.	Date signed (Month,	Day, Year) 2004	
	(3		30. Name and address of person who completed cause LSC be le It ERT	of d th (Item 23a) (Ty	pe, Print Shad	y Grove	Hospit	=1- Pa	choille_	
	Sta Registi		31. Date filed (Month, Day, Year) 0CT 12 2004 32. Pe	gistrar's Signature	Sporks	/				

State of Maryland / Department of Health and Mental Hygiene 1- State RegistrateD #23a(b)perMD10/13/04,EMW,MoCo Certificate of Death U U 4 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** ISADORE JACK PARKER JC7015216 11 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** DOCTORS HOSPITAL LANHAM PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Nov 17, 19 9. Birthplace (State or Foreign **Funeral** Days 1 X M 2 □ F Months Hours Min 84 Illinois Director 318-18-5087 Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location Show 10d. Inside City Limits in than "natural", or Items 23a or 28a-f show 1 ⊋Yes 2 □ No Director Maryland Prince George's Greenbelt 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8150 Lakecrest Drive, #111 20770 death v United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married ☐Yes 2X No 1 ☐ Yes 2 X No Specify: þ Specify. 3 ☐ Widowed 4 🛱 Divorced Year or Dates: WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Maryland Park and Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygier
Important: If them 27 is marked other th
any injury or other traumatic event, IIIs
once. Planning & Zoning Engineer Planning Commission Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Max Parker Goldie Davidov 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8012 Yorktown Drive, Alexandria, Virginia Naomi P. Hatch, daughter 22308 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 X RemovaL from State 4 Donation 5 Other (Specify) NATIONAL CREMATORY Oct 13,2004 FALLS CHURCH, VIRGINIA uneral Service Licenses 21. Signature of DANZANSKY-GOLDBERG_MEMORIAL CHAPELS, INC 1170 ROCKVILLE PIKE, ROCKVILLE, MD 23a. Party Enter the disease or complications that caused in shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** hronic /Medical Due to (or as a consequence of) **Examiner** Diabetes Mellitus 10 yrs. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Examine sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 attending physician for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) Records, P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Heart Disasse 24a. Was an autopsy performed 24b. Were autopsy lindings available prior to completion of cause of death? 2 No 1 ☐ Yes Division of Vital 2 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? 5 Pending investigation 1 X Natural after death. 1 Yes 2 No 2 Accident in by the 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide within 24 hours a To the Funeral C filled 29a. Certifier 1 Scrifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 10037117 10 who completed cause of death (Item 23a) (Type, Print) w 7500 Honover May 204' Greenley, Schwart, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 13 Registrar 2004

			1- For State of Maryland / Dep	partment of Health and Mertificate of Death		2004 34178
	Physic		1. Decedent's Name (First, Middle, Last) William L. Perry, Sr.		2. Date of Death Month October	Day Year 7 2004 6:00 P M
	/Medi Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			Villa Rosa Nursing Home 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Mitchellvil J If Under 1 Year If Under 24 Hrs.		Prince George's
	Funeral Director		058-14-1979 1 M 2□F 84 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day,) Jan. 10,	Year) 9. Birthplace (State or Foreign Country) North Carolina
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	a-f sho	ctor	Maryland Prince George's	Upper Marlboro		14 Yes 2 □ No
	with the	Director	10e. Street and Number 13603 Missoula Ct.	10f. Zip Code	100	. Citizen of What Country?
	death ms 23	Funeral		20774 Was Decedent of Hispanic Origin? (Spell Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	United States 14. Race - American Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any njury or other traumatic event, the Medical Examinar could be notified at ances.	by Fur	1 Never Married 2 Married 1. Syes 2 No If Yes, Give	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	Rican, etc.)	Black, White, etc. AITICAN Specify:
Maryland 21215-0036	72 hour	ted t	15. Decedent's Education 16a. Dece	edent's Usual Occupation	16	American b. Kind of Business/Industry
121	within 7	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of worki DO NOT use retired)		0
2	il Hygie other ont, II	Be Co	17. Father's Name (First, Middle, Last)	chanic/Longshoreman		Government iden Surmarne)
ylar	ould be Menta arked atic ev	To B	Sam Perry		Senora	Parker
	nd 2 sh Ith and 27 Is m traum		· · · · · · · · · · · · · · · · · · ·	ing Address (Street and Number or Rura		
Baltimore,	of Hea of Hea fitem		20a. Method of Disposition 20b. Place of Dispo	3603 Missoula Ct., osition (Name of punatory or other place)		c. Location - City or Town, State
‡ T	t. Pag rtment rtant: I		`4 □ Ponation 5 □ Other (Specify) Harmony	Memorial Park 10/14		Landover, MD
a D	Department of the popular of the pop			$^{2. ext{Name and Address of Facility}}$ Ste 4001 Benning Rd., N		
Ü,			23a. Part / Enter the disease, or complications that caused the death. Do not en shock or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac o	r respiratory arrest	Approximate Interval Between
)	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Aspiration Pnet Due to (or as a consequence of):	ımonia		Onset and Death Several Days
8760,	death certificate be executed e attending physician and id for use as the burial-transit	dical Examiner		a with agitated fea	atures	Severl Years
.O. Box 6	death certifi e attending i ed for use as	by Physician/Mec		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
rds, P	The law requires that the site has been signed by the bage 2 should be detache		Part II. Other significant conditions contributing to death but not resulting in the u	ınderlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
II Records,		Completed			24a. Was an autopsy performer	24b. Were autopsy findings available prior to completion of cause of death? 1 No 1 □ Yes 2 □ No
Vital	sician: Th certificate lirector, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	26. Place of Death		
Division of	or Attending Physician: ufer death. Director: After this certific in by the funeral director,	\vdash	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury		8d. Describe how	e 6 Liother (<i>Specify)</i> injury occurred
DIVIS	tal or Attendes safter death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stream building, etc. (Specify)	reet, factory, office	8f. Location (Stree City or Town, S	t and Number or Rural Route Number, late)
	To the Hospital o within 24 hours aft To the Funeral Di completely filled in	Medical (29a. Certifier (Check only one) Medicel Exeminer: On the basis of pxamination and/or in and manner stated.	h occurred at the time, date and place, a vestigation, in my opinion, death occurre	nd due to the caus od at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	with.	Σ	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
0			30. Name and address of person who completed cause of death (Item 23a) (Type,	D22780		October 12, 2004
1	(10)		Peter M. Schissler, M.D. 7500 Gr		430; Gree	nbelt, MD 20770
	Sta Registr	_	31. Date filed (Month, Day, Year) OCT 1 4 2004 32 Registrar's Signature	and the second		

State of Maryland / Department of Health and Mental Hygienes For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Josephine Pualisi а м October 11, 2004 /Medical 1:30 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 2101 Hermitage Avenue Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year June 30, 1 Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🗓 F 96 Director 578-03-8376 Yrs Italy Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location ir than "natural", or itama 23a or 28a-f show the Medical Exercit er must be notified at 10d. Inside City Limits 1 ☐ Yes 2 TNo Directo Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 2101 Hermitage Avenue 20902 Funerai USA death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ĀNo If Yes, Give Year or Dates: Specify: White Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 No Specify: 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 7. h and Mental Hygiene. 7 Is marked other than "ne Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Antonio Briguglio Carmela Sentineri 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If itam 27 Is n any injury or othar traun 20b. Place of Disposition (Name of cametery, crematory or other place)
Fort Lincoln Anthony A. Puglisi/ Son 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State * 4 ☐Donation 5 ☐ Other (Specify) 2004 B Brentwood, Maryland Cemetery 21. Signature of Funeral Service Licen 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or rear failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Myocardial Infarction /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) The law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy ò in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ Depression, Thyroid Goiter, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has Cataracts autopsy performed? page certificate 1 ☐ Yes 2 X.No the Hospital or Attanding Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: ${}_{4} \square$ Nursing Home ${}_{5} \boxtimes$ Residence ${}_{6} \square$ Other (Specify) ပ 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending after death.

Director: Aft
d in by the fun investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide To the Hospital ewithin 24 hours at To the Funaral D 1🛛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) TON D34472 October 12, 2004 30. Name and address of person who completed cause of death (Item 10 Lynne Diggs, 31. Date filed (Month, Day, Year) 10400 Connecticut Avenue #202, Kensington, MD 20895 State 13 oaks Registrar

		Please Type or Print in Black State of Maryland / D					_	ble.		
			-	ficate of			Reg. No.	04	34180	
Physicia /Medic		1. Decedent's Name (First, Middle, Last) Hilda M. Pietrasanta				2. Date of Da Month	- 92	2004	3. Time of Death	
Examine	er	4a. Facility Name (If not institution, give street and number) North Arundel Hospital	41	b. City, Town, o	Burni			Anne Arundel		
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth		Under 1 Year lonths Days	tf Under 24 Hrs Hours Min.	8. Date of Birt	th y, Year)		plece (State or Foreign intry)	
Director		Usual Residence of Decedent	S.			Dec.	27,1913		PA	
death with the Maryland ms 23s or 28s-f show trast be notified at	ctor	10a. State MD 10b. County 10c. City, Town Anne Arundel		Pas	sadena				10d. Inside City Limits 1 ☐ Yes 2 💆 No	
with th	i Dire	8016 Ritchie Hwy.		10f. Zip Code 2112	22		10g. Citizen of \		intry? ISA	
21215-0036 d within 72 hours effer death with the Maryla piene. r then "natural", or Hema 23e or 28e-1 ehov the Medical Exeminer must be notified at	y Funerai Director	11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S. Amed Forces? 1 □ Yes 2 ☒ No If Yes, Give	If Ye	s Decedent of Hess, specify Cuba	dispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No to Rican, etc.)	- 14. Rac Btac	ck, White,	ican Indian, , etc. nite	
P Dours	ted by	15. Decedent's Education 16a. I)ecedent	's Usual Occup	pation		16b. Kind of Bu			
id 21215-0036 id 21215-0036 illed within 72 hours elter of Hygiene. other then "natural", or iter other then "matural", or iter wedical Examination.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		d of work done NOT use retired dminist	during most of word)	rking	Dod	l Cro		
laryland 212. 2 should be filed within and Mental Hygiene. Is marked other then eumatic event, train	Be Co	12 17. Father's Name (First, Middle, Last)		CUILLITS		ne (First, Middle,			55	
arylan should be and Mental be umartic even	ToB	Umberton Spadacene			Flora					
Maryland nd 2 should be file fill and Mental Hy 27 is marked other treumatic event					and Number or Ru Ld Drive,				ip Code) 21108	
it in men other		20a Method of Disposition 20b. Place of D	Dispositio			Date 11,	20c. Location -	City or T	own, State	
Baltimore, permit Peges 1 a Department of Hee Important: If item eny injury or othe once.		'4 □Donation 5 □Other (Specify) 21. Signature of Euneral Service Licensee		ematory	i	2004	Baltimo			
Ball Ball Ball Ball Ball Ball Ball Ball		Eldig & allen	10E	Corr T	Ditabia II	Corre	Dane	k Fu	neral Home	
		23a Part. Enter the disease, or complications that caused the death. Do no shock, or rearr ailure. List only one cause on each line.	t enter th	ne mode of dyin	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death	
Priysician /Medical		Immediate Cause (Finat disease or condition resulting in death) a. Due to (or as a consequence of):					-		
Examiner	_	IMENARY T		4/1	FE47D	N				
ğ ë	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of	JB.	QUAT!	EGID.					
687 ilificate g physi	edica	d								
ds, P.O. Box 687 irres that the death certificate is signed by the attending physid be detached for use as the d	Physician/Medic	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown		opic pregnancy her (specify)	1		23d. Dat Mor	te of deliventh	rery Day Year	
es the ped	þ	Part II. Other significant conditions contributing to death but not resulting in t	he under	rlying cause giv	en in Part I.	23e. Did to	S. A.		the cause of death?	
Division of Vital Records, To the Hospitel or Attending Physician: The law requires t within 24 hours after death. To the Funerel Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be	Completed					24a. Was autop	rmgedy2 c	Were auto prior to co death?	opsy findings available impletion of cause of	
Vita vician: certific	o Be (25. Was case referred to medical examiner?		Oth	ar.	th (Check only o				
n of ag Physics the this neral di	⊢⊹	27. Manner of D - th 28a. D -e of Injury 28b. Tin	ne of	3 DOA 28c. Injun	y at	ome 5 Resid	lence 6 Other		(y)	
isior tendin death. to: Af the fur	catic	2 Accident investigation		M 1 🗆	Yes 2 □No	ORA Lacation (C				
Divi	Certification:	4 Homicide 4 Homicide 4 Homicide 4 Suicide 4 Suicide 4 See. Place of Injury - At home, fam building, etc. (Specify)	ı, Street,	factory, office		City or Tow	treet and Numbern, State)	er or Hura	al Route Number,	
Hospit 24 hours Funere	Medicai (29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one) (Check only one)	death oca	curred at the tin igation, in my o	ne, date and place pinion, death occu	, and due to the or rred at the time, or	ause(s) and ma date and place, a	nner as s and due t	itated. o the cause(s)	
To the within 2 To the comple	Mec	one) and manner stated. 29b. Signature and title of certifier	-	29c. License	e number	:	29d. Date signed	1 (Month,	Day, Year)	
		MD.		D4	3977	1	0 ctober	9	2004.	
		30. Name and ad ress of person who completed cause of death (Item 23a) (T	/pe, Prin	we K	len B	limal	MD	2	1061	
Stat Registra	.5	31. Date filed (Month, Day, Year) 32. gistrar's Signature	Ana	all i		VV V V V				
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_			1 - For State of Maryland / Dep Registrar Ce 1. Decedent's Name (First, Middle, Last)	artment of Health and I rtificate of Death	Reg. I	2004 34181									
	hysicia /Medica xamine	af L	Clara Bell Rosier 4a.Facility Name (If not institution, give street and number) Hospice of Baltimore at Gilchrist Center	4b. City, Town, or Location of Death	Oct. 20	4c. County of Death									
_	neral ector		5. Social Security Number 6. Sex 1 M 2 F 86 Yrs.	TOWSON If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Jan. 13, 1	Baltimore 9. Birthplace (State or Foreign Country) Virginia									
Maryland	be notified at	. [Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or L MD Baltimore Whit	ocation e Hall		10d. Inside City Limits 1 ☐ Yes 2 🛣 No									
th with the	23a or 28 ist be rud	al Director	10e. Street and Number 2139 Gibson Road	10f. Zip Code 21161		Citizen of What Country?									
1215-0036 within 72 hours after death with the Maryland	3	by Funeral	1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White									
1215-0 within 72 ho	than "netural" he Madical Ex	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of wor DO NOT use retired) TMC 1		Kind of Business/Industry Dairy Farm									
4:30 AM Baltimore, Maryland 21215-0036 Permit. Pages 1 and 2 should be filed within 72 hours all	Neur l	To Be Co	17. Father's Name (First, Middle, Last) Elihue Snow	18. Mother's Nan	ne (First, Middle, Maid ae Strou	en Sumame)									
Maryle and 2 should eastly and Mer	n 27 is ma her trauma	1	Grace L. Orwig/Daughter 213	ing Address (Street and Number or Ru 9 Gibson Rd., V	White Hal	1, MD 21161									
timore	Importent: If Item 2 any injury or other QDC9.			st Cemetery 200	. 24,	rkton, MD									
Bal Bal	any ir once.		21. Signature of Fun val Service Usensee 22. Name and Address of Facility J. J. Hartenstein Mortuary, Inc. 24. Second St., New Freedom, PA 17349 23a. Payl. Erter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Bet Interval Bet												
Exam	ician edical niner	ıer	Immediate dause (Final disease or condition resulting in death) a		Onset and Death Years										
68760, S. difficate be executed	lysicie ne bur	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):												
OBER O. Box 6	by the attending tached for use as	by Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year									
rds, P	been signed t	ed by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc 1 ☐ Yes	o use contribute to the cause of death? 2 No 3 Probably 4 Unknown									
A reco	ate has	Completed			24a. Was an autopsy performed 1 Yes 2 X I										
SOS on of	After this funeral di	atlon: To Be	25. Was case referred to medical examiner? 1 Yes 20 No	ent 3 DOA Other: 4 Nursing H	ome 5 Residence 28d. Describe how in	1 2 1 101									
	To the Funeral Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, larm, si building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)									
CLAR Dis the Hospitel or	the Funer	Medical	29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or is and manner stated.	nvestigation, in my opinion, death occu	rred at the time, date a	and place, and due to the cause(s)									
To the within 2	Con	2	29b. Signature and title of certifier.	29c. License number D 58303		Date signed (Month, Day, Year) WWL 20 2004									
	H		30 Name and address of person who completed cause of death (Item 23a) (Type CAPA) (Type CA	Marles BAZTIM	ere no	21204									
177.5	Stat Registra	ie ar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1-3.											

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygier 004 34182 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October **Physician** Kuzicka 10100 PM Kaymond 2004 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MAR 4 1945 Johns Hoplans The 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Director NEBRASKA 506-62-1747 Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits Item 27 is marked other then "natural", or items 23e or 28e-f show other traumatic event, the Medical Examinar must be notified at MD TRAPPE 1 ☐ Yes 2 X No TALBOT Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1646 FERRY POINT COURT 21673 USA death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 10 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If Item 27 Is marked other then "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: ģ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 REGIONAL MANAGER TAX SERVICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JOSEPH RUZICKA HELEN JANKY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) IRENE C. RUZICKA/WIFE 1646 FERRY POINT COURT, TRAPPE, MD 21673 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. WOODLAWN MEMORIAL PARK 10-5-2004 EASTON, MARYLAND A □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses The proximate state of the part of the par 22. Name and Address of Facility Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Intracerebra nemorrhage Physician /Medical Due to (or as a consequence of): Examiner escul Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ţ in the past 12 months?
1 Yes 2 No Month Day 4☐Pregnant at time of death 5 Other (specify) þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ cate has been sig page 2 should b 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2□ No 1 Yes 2 0 No 1 Yes Hospitel or Attending Physician: director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nnpatient 1 ☐ Yes 2 XNo 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 To the 29b. Signature and title of certifier M.P. RES 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Clinton 600 North Wolfe Bultimore Street 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 2004 Registrar

			1 - For State Registrar	State of Ma	aryland / Do	epartment of F Certificate of	lealth and M	lental Hy	gien 2 () Reg. No.	
	Physic /Medi			MARIE	RECCHI			2. Date of De Month OCTOBI	Day	3. Time of Death 3:35 Pt
	Exami	ner	4a. Fecility Name (If not institution, give ROCKVILLE NURS	ING HOME	()	ROCKVI				GOMERY
	Funeral Director		5. Social Security Number 146 24 4202 1 Usual Residence of Decedent	DM 2X F	71 Yr	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Dec. 2	2 1932	9. Birthplace (State or Foreig Country) New Jersey
	e Maryland ta-f ehow	ctor	Md. 10b. County Md. Montgo	mery	10c. City, Town Clar	ks burg				10d. Inside City Limit 1 ☐ Yes 2 🕱 No
	th with th 23a or 28 ust be no	Funeral Director	10e. Street and Number 12305 Fountai	n Drive		10f. Zip Code 208	371		10g. Citizen of Unit	What Country? ed States
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural; or items 23e or 28e-1 ehow any injury or other traumatic event, the Medical Examiner restricts and approx.	by Fune	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent B Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		13. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	spanic Origin? (Spe n, Mexican, Puerto i Specify:	cify Yes or No Rican, etc.)	- 14. Rad Bla Specif	ce - American Indian, ck, White, etc. y: White
1215-0	within 72 ho ene. than "natu ne Medical	Completed by	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de <i>completed)</i> College (1-4or 5	+)	ecedent's Usual Occupa Give kind of work done of the DO NOT use retired ISTructiona	furing most of workir)			usiness/Industry y Schools
Maryland 21215-0036	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the M	To Be Co	17. Father's Name (First, Middle, Last) Mario Profit	a		is cruc crona	18. Mother's Name	(First, Middle,		
	and 2 should ealth and Men n 27 is marke er traumatic		19a. Informant's Name/Relationship (7			Mailing Address (Street a				
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ 1 ☐ Donation 5 ☐ Other (Specify,		cemetery,	isposition (Name of crematory or other place Wn Memoria	9)	ate 04		City or Town, State wn, New Jersey
Balt	Departr Departr Imports any inju		21. Signature of Funeral Service Licens	Barker	,	Name and Address Muriel H. P. O. Box	Barber Fu 5038, La	uneral avtonsv	Home ille, M	d. 20882
	Physician /Medical		23a. Pert1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. CANCE	θ.	enter the mode of dying	, such as cardiac or	respiratory ar	rest,	Approximate Interval Between Onset and Death
79	Examiner publication of the property of the pr	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. HYPER		HEART DISEA	ISE			
68760,	rcate be executed physician and s the burial-transit	cai	resulting in death) Last	Due to (or as a	consequence of):					
.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at the good Unknown	Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Dai Mo	e of delivery nth Day Year
rds, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions co	ntributing to death bu	t not resulting in th	e underlying cause give	n in Part I.			ibute to the cause of death? 3 ☐ Probably 4 Munknown
al Kecords,		Completed						24a. Was autop perfor 1 Yes	sy p	Vere autopsy findings available rirer to completion of cause of eath?
or Vital	Physician: this certific ral director,	To Be	I BS ZZNYO	Hospital:			4 🖾 Nursing Hom			or (Specify)
DIVISION	After	Certification:	27. Manner of Death 1 ∑Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28a. Date of Injury (Month, Day	Year) Injui	ry Work' M 1 □ Y	es 2 No		ow injury occurr	
_	7 9 12 -		4 Homicide determined	building, etc.	(Specify)	street, factory, office		City or Tow	n, State)	er or Rural Route Number,
	To the Hospital of within 24 hours at To the Funeral D completely filled in	Medicai	one)	ner: On the best of ner: On the basis of and manner state	axamınation and/oi	eath occurred at the time r investigation, in my opi	nion, death occurred	d at the time, o	late and place, a	nd due to the cause(s)
	To To		29b. Signature and title of certifier	V Dr	10010	29c. License	number 7330	2		(Month, Dey, Year)

State Registrar THOMAS JOSEPH, M.D.

31. Date filed (Month, Day, Year)

OCT 13 2004

50 W.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EDMONSTON DRIVE, ROCKVILLE, MD.

20852

			1 - For State Registrer	State o	f Maryland / De _l	partment of Hertificate of I	lealth and <i>Death</i>		gien 2004	34184
	Physici /Medic		Decedent's Name (First, Middle,		t RUSIN			2. Date of Dea Month October	11, 200 ^{Year}	3. Time of Death 9:53 A M
	Examir		4a. Facility Name (If not institution, 12546 Post Cree	•	mber)	4b. City, Town, or			4c. County of Death	
	Funeral Director				7. Age (In yrs. last birthda 49 Yrs.	Germant y) If Under 1 Year Months Days		n. (Month, Day	Montgom (1) Year) 9. Birth (2) 9, 1955 Peni	place (State or Foreign intry)
	/land		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location		Apr II 2	2, 1970 Fem	10d. Inside City Limits
	Ba-fsh	Director	Maryland Montg	omery	(ermantown				1 ☐ Yes 2 📉 No
	with the or 2		10e. Street and Number	1 -1		10f. Zip Code		1	log. Citizen of What Cou	intry?
	deeth me 23	Funerai	12546 Post Cree	12. Was Dece	edent Ever in U.S. 13	2087 B. Was Decedent of Hi If Yes, specify Cuba		Specify Yes or No-	United Stat	
920	within 72 hours after deeth with the Maryland ane. then "natural", or iteme 23e or 28e-1 show he Madigal Examirer mast be notified at		1 Married 2 Married 3 Widowed 4 Divorced	Armed For ed 1 ☐ Yes If Yes, Giv Year or Da	2 X No	If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	n, Mexican, Pue Specify:	orto Rican, etc.)	Black, White	nite
5	72 ho "natur	eted	15. Decedent' (Specify only highest		(Giv	edent's Usual Occupa	during most of w	orking	16b. Kind of Business/Ir	ndustry
121215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "natural; or iteme 23s or 28s-f show among injury po other traumatic event, the Madical Examiner must be notified at ance.	Completed by	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, L	College (1	-40r 5+)	no NOT use retired		<u>F</u>	National Ins Nealth	stitutes of
Maryland	ld ba fi ental H ked ot ic ever	To Be	Jack Rusin	asi)			Liane	me (First, Middle, I	Maiden Surname)	
ary	and M le mar	-	19a. Informant's Name/Relationsh	ip (Type, Print)	19b. Ma	ling Address (Street a			, City or Town, State, Zij	o Code)
	and 2 fealth im 27 her tra		Mark Rusin, Bro	ther		Forrest Pa		The state of the s		
Baltimore,	ages Intoff		20a. Method of Disposition 15 Burial 2 Cremation		O.C.O.	oosition (Name of ematory or other place	1		20c. Location - City or T	
alti	mit. P partme sorten / injury		* 4 □ Donation 5 □ Other (Sp 21. Signature of Funeral Service L) 0	emorial Pa 22. Name and Addres	s of Facility		Lower Morel	and, PA
<u>~</u>	Depar Impo		* ybotski	Derole	T	orchinsky	Hebrew	Funeral H	lome	10012
			23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that cannot one cause on ea	aused the death. Do not e ach line.	nter the mode of dying	g, such as cardia	ac or respiratory arre	gcon, DC 2	Approximate Interval Between Onset and Death
}	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	ardial Infar	ction				Oliset and Oeath
	Examiner		Conventially list and distance	b	or as a consequence or,					
	be sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter of Janying Cause (Disease or injury		or as a consequence of):					
	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	c	or as a consequence of):					
8760,	ysicia	dicai		d						
9	ertifica ling ph	Med	IF FEMALE:	00- 14						
O. Box	The law requires that the death certifi tie has baen signed by the attending tage 2 should be detachad for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1☐Live bi	ant at time of death 5	□Ectopic pregnancy □ Other (specify)			23d. Date of delive Month	ery Day Year
s, G	as that igned by be deta	by Ph	Part II. Other significant condition	s contributing to de	eath but not resulting in the	underlying cause give	n in Part I.	23e. Did tob	pacco use contribute to the	he cause of death?
ords	w requira baen sig should b		Type I Diabetes	Mellitus	5			1 ☐ Ye	s 2∏No 3∏Prob	pably 4 Unknown
Record		Completed						24a. Was ar autopsy perform 1 \sum Yes 2	y prior to co	psy findings available mpletion of cause of
Vital	iclan: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:		Otho		ath (Check only one	9)	
Division of	Attending Phyeician: r death. ector: After this certification the funeral director.	on: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date o	npatient 2 ER/Outpatient 28b. Time h, Day Year)	of 28c. Injury Work	at at	Home 5 X Resider 28d. Describe ho	nce 6 Other (Specification of the control of the co	y)
S	Attend death ctor: / y the f	ficat	2 Accident investigated a Could not determine	ot be	of Injury - At home, farm, s		′es 2 □ No	28f Location (Str.	reet and Number or Rura	I Pouto Number
2	tal or A s efter al Director	Certification:	4 Homicide	buildin	ng, etc. (Specify)	and a control of the		City or Town	, State)	ir route reamber,
	To the Hospital or Attent within 24 hours efter deatl To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 XCertifying (Check only one)	Physician: To the xaminer: On the ba and mann	best of my knowledge, dea sis of examination and/or i er stated.	th occurred at the time nvestigation, in my op	e, date and place inion, death occ	e, and due to the ca urred at the time, da	use(s) and manner as si	ated. the cause(s)
	To t To t	×	29b. Signature and title of certifier	. //	110	29c. License			d. Date signed (Month,	
•	20		All All	<i>H</i> —	IND		57362		October 11,	2004
	V		30. Name and address p son w Jean R. How, M.I				v. Germa	antown MI	D 208 76	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Rg	gistrar's Signature	Sparks				
	in egion		001 -0	C004 /4	100	1000 or cons	-			

State of Maryland / Department of Health and Mental Hygien 2004 Certificate of Death 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last, Year **Physician** Ruth Alberta Shoemaker October | 20 2004 7:15 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Northampton Manor Nursing Home Frederick

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Frederick Frederick 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🖫 F 95 June 28, 1909 213-16-1052 Director Maryland Usual Residence of Decedent with the Maryland 10a. Slate 10b. County 10c. City, Town or Location 10d. Inside City Limits "naturel", or items 23a or 28a-f show idical Examiner must be notified at 1 Yes 2 □ No Directo Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Cilizen of Whal Country? 100 Burgess Hill Way #315 21702 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. nnt: If item 27 is marked other than "naturel", or iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: Specify: White Completed by 3 XWidowed 4 Divorced the Medical 16a. Decedenl's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owner and Operator Retail Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Maurice E. Blank Anna Elmira Stockman 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) R. Imogene Rowe/Daughter 5321 Shookstown Road, Frederick, Maryland, 21702 permit. Pages 1 and Department of Health Importent: If item 27 any injury or other t once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 ▼ Bunal 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Rocky Springs Cemetery 10/25/2004 Frederick, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 106 East Church Street Millian 0 Keeney and Basford P.A. Funeral Home Frederick, MD, 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYO CHILDIAL **Physician** IN FARCTION MONTHS. /Medical Due to (or as a consequence of): Examiner () HEU MONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed FAILURE physician and s the burial-trans to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical as the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 ☐ Fetal death in the past 12 months? Month Day Year 4 Pregnant al time of death 5 Other (specify) signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 2 No 3 Probably 4 Unknown 1 ☐ Yes page 2 should Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performe certificate 2 No 1 Yes 2 No 1 Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 2 1 Yes 2 No 1 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA in by the funeral 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury al Work? 28d. Describe how injury occurred Certification: After 5 Pendina 1 ☐ Yes 2 ☐ No investigation M 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours To the Funerel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number War 10-21-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AUE FREDERICK MD SIBTE A. KAZMI, HOUSE क्षाप Tou מח

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) OCT 2 7

32. Registrar's Signature

			For State Registrar			epartment of F Certificate of	Death	Reç	en2004	34186
	Physici	an	Dale Dale	fdle, Last)	Scha	idt	2	Date of Death Month	Day Yeer	3. Time of Death
	/Medid Examin		4a. Facility Name (If not instituti	ion, give street and numb	per)	4b. City, Town, o	or Location of Death	10	4c. County of Death	
			SACRED H		fOSPITA		BERLAND		ALLEGA	-/
	Funeral Director		5. Social Security Number 216-22-6508 Usual Residence of Decedent	6. Sex 7. 1 ☑ M 2 ☐ F	Age (In yrs. last birti	hday) If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Day, 1) Feb 24,	1926 9. Birthy Coul	plaće (State or Foreign ntry) MD
	aryland show	_	10a. State 10b. Coun	egany	10c. City, Town	or Location				10d. Inside City Limits
	28e-f	recto	10e, Street and Number			10f. Zip Code		100	g. Citizen of What Cou	1 Yes 2 No
	3e or	al Dir	P.O. Box 22			75 2.p 5555	21555		USA	My.
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "natural", of Items 23e or 28e-f show other treumetic event, the Medical Examinat must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorce	If Yes Give	es?	13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 → No	Hispanic Origin? (Specifian, Mexican, Puerto Ric Specify:	fy Yes or No- can, etc.)	14. Race - Ameri Black, White, Specify:	etc.
2-00	72 hou natura lical E		15. Decede	ent's Education hest grade completed)	16a.	Decedent's Usual Occup (Give kind of work done	pation during most of working	16	5b. Kind of Business/In	
121	within and then "then "	Completed	Elementary/Secondary (0-12		or 5+)	(Give kind of work done life. DO NOT use retire ming Mill	d)		Railroad	
id 2	filed with Hygiene. other ther	Be Co	17. Father's Name (First, Middle		ļi id	ming will	18. Mother's Name (F	First, Middle, Ma	aiden Sumame)	
ylar	2 should be and Mental is marked c	To E	Joseph M. S				Ethel P. (
Maryland 21215-0036	nd 2 shulth and 27 is m		19a. Informant's Name/Relation Rick Schaidt	nship <i>(Type, Print)</i> SOT	າ F	Mailing Address (Street P.O. Box 794	and Number or Rural F	Ridgele Ridgele		V 26753
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation		cemeter	Disposition (Name of y, crematory or other pla emorial Cemet	Ce) Dat		Oc. Location - City or To	
altim	4 E E E		'4 ☐ Donation 5 ☐ Other 21. Signature of Funeral Service		Davis ivi		as of Facility III Funeral Hon		Cumberland	d MD
Ä	Depa Impo any ii		Cam	es 7 AM	le		ginia Avenue:		nd, MD 21502	,
	Fnysician /Medical Examiner		23a. Part1. Eyer the disease, shock, of heart failure. Li Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	aDue to (or	en line. A dis a ras a consequence of	go patay	ng, such as cardiac or r	espiratory arres	t,	Approximate Interval Between Onset and Death
68760, A	death certificate be executed e attending physician and nd for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	as a consequence of					
.O. Box	at the death certificat by the attending phy tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		h 2 Fetal death	3 ☐ Ectopic pregnance	у		23d. Date of delive Month	ery Day Year
rds, P.	quires that on signed b	by	Part II. Other significant condi	itions contributing to deal	th but not resulting in	the underlying cause gr	ven in Part I.		cco use contribute to to	he cause of death?
al Records,	nysicien: The law requires that the is certificate has been signed by the director, page 2 should be detached.	Completed						24a. Was an autopsy performe	prior to co death?	ppsy findings available impletion of cause of
Vital	Physicien: rthis certific ral director,	To Be	25. Was case referred to medic examiner? 1 Yes 2 No	Hospital:	oatient 2 ER/Out	patient 3☐ DOA Ott	26. Place of Death (C		ce 6 Other (Specif	(v)
n of	<u>a</u>		27. Manner of Death 1 ☑Natural 5 ☐ Pend	28a. Date of (Month,		ime of 28c. Injury Wo	ry at 28d rk?	d. Describe how		77
Division	ten leat lor: the	Certification;	3 Suicide 6 Coul	mined 288, Place of	f Injury - At home, far J, etc. <i>(Specify)</i>	M 1	Yes 2	Location (Stre City or Town,	et and Number or Rura State)	ıl Route Number,
1	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	Medical Ce	29a. Certifier 1. Certify (Check only one) 2 Medic	ying Physician: To the basi all Exeminer: On the basi and manner	is of examination and	, death occurred at the ti	me, date and place, and opinion, death occurred	d due to the cau at the time, date	se(s) and manner as s a and place, and due to	lated. the cause(s)
	To the within To the complete	Me	29b. Signature and title of pertin	fier		29c. Licens		1	d. Date signed (Month,	
			1 Vm	1			0766	0	october 2	1,2004
	8		Pooners Vikro	on who completed cause		Type, Print) 2ton Drive	Cumber	land, A	ND, 2150	.2
	Sta Registi		31. Date filed (Month, Day, Yea		gistrar's Signature	B Spor	de la			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year EVERAL PAULINE SIBLEY OCTOBER 19,2004 2:00 P.M. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frostburg Village Nursing Home Frostburg Allegany If Under 24 Hrs. Hours Min. 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Days Months 1 M 2 JF Yrs. 212-18-1967 Director 84 May 31, 1920 Μ̈́D Usual Residence of Decedent реттіt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 Is marked other then "neturel", or items 23e or 28e-f show 10a. State 10c. City, Town or Location r then "neturel", or items 23e or 28e-f show the Medical Examiner must be notified at 10d. Inside City Limits MD Allegany Cumberland Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1310 Oldtown Road 21502 USA Funeral 11, Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ☐ Yes 2☐ No Yes, Give X altimore, Maryland 21215-0020 1 ☐ Yes 2 ZXNo Specify: <u>ک</u> Specify. 3 X Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Service Technician Memorial Hospital or other treumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick W. Hamilton Sophia Ritter Hamilton 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlene McConnell 639 Hilltop Drive daughter Cumberland MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Purial 2 □ Cremation 3 □ Removal from State 10/23/2004 Cumberland 4 □ Donation 5 □ Other (Specify) Greenmount Cemetery MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 NM Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, repair heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Cerebral two weeks Examiner Due to (or as a consequence of) Examiner attending physician end for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physiclan/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 3 ☐ Probably 4 ☐ Onknown 1 Yes 2 No Division of Vital Records, \$ page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has 2000 1 TYes 1 Yes 2 THO To the Hospital or Attending Physicien: "within 24 hours efter death."
To the Funerel Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Matural 2 No 1 ☐ Yes 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00055325 Worseekellen Oct 21, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WONSOCK -SHIN MD 48 Tarn MD21532 Terrace Frostburg 32. Registrar's Signature State 2004 Registrar

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiens 34188 For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) october 12, 200^{Year} **Physician** DOROTHY SLAVEN 6:05 P. M. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner COLLINGSWOOD NURSING HOME ROCKVILLE MONTGOMERY 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1□M 201F Months Hours Min. Montgomery Director 472-10-2194 99 JAN. 15, 1905 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County in than "natural, or Items 23a or 28a-f show the Medical Examination at collified at 1X Yes 2 □ No Bethesda Directo Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20817 8508 Ewing Drive U. S. A. death Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. be filed within 72 hours after 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 ☐ Widowed 4 X Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) 12 Years College (1-4or 5+) Dress Shop Sales Lady Pages 1 and 2 should be filed v riment of Health and Mental Hygie rtant: If item 27 is marked other t njury or other traumatic event, in 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Dora Shimelgore Herman Slaven 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HILARY D. GREENBAUM - NIECE 805 HARRINGTON ROAD, ROCKVILLE, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If eny injury or NATIONAL CREMATORY 10/21/04 FALLS CHURCH, VIRGINIA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility EDWARD SAGEL EUNERAL RIRECTION; INC. 1091 ROCKVILLE PIRE, ROCKVILLE; MARYLAND Donald C. 20352 Hottlem 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death End Stage Advanced Dementia Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or highly that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown ģ been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 certificate 1 ☐ Yes 2√ No Physician: ector, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 ☐ Yes 2X No à this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Attending 1 Xatural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation in 24 hours after death the Funerel Director: / npletely filled in by the f 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ŏ within 24 hours a To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00585 OCTOBER 13, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUITE 404B, SILVER SPRING, MARYLAND 8609 2ND AVENUE, RABI PASSI

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

2004

		. 101	partment of Health and Menerificate of Death	ntal Hygien 004	34189
Physic /Medi	cal	Decedent's Name (First, Middle, Last) Alton Edward Snyder 4a. Facility Name (If not institution, give street and number)	1	Date of Death Month Day Yea 106FL 106FL 4c. County of De	4 10884 4W
Exami Funeral Director		Washington County Hospital 5. Social Security Number 6. Sex 215-42-3030 62 F Age (In yrs. last birthda	Hagerstown	Washingto	on County Sirthplace (State or Foreign Country) Aryland
death with the Maryland ms 23a or 28a-f show trivust be notified at	Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Maryland Washington Williams 10e. Street and Number 10c. City, Town or		10g. Citizen of What	10d. Inside City Limits 1 Yes 2 No
after or Its	by Funeral	17125 Miner Ave 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	21795 3. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica	U.S.A. Yes or No- an, etc.) 14. Race - Ar Black, W.	merican Indian,
4 12 13-UU3 d within 72 hours giene. sr than "netural", the Madical Ex-	completed	15. Decedent's Education (Graphic Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12	cedent's Usual Occupation we kind of work done during most of working by DO NOT use retired) achinist	16b. Kind of Busines	anufacture
hould be filed Americal Mould be filed Mental Hygemarked other mattic event,	To Be C	17. Father's Name (First, Middle, Last) Alton W. Snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Ma		rst, Middle, Maiden Surname) • Kelbaugh oute Number City or Town State	Zin Codel
nore, Mar ages 1 and 2 sho not of Health and t: If Item 27 Is m y or other treum		Phebe L. Snyder (Wife) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 1 Popularion 5 Dottor (Specific) Parklaw	125 Miner Ave. Willia position (Name of rematory or other place) ns Memorial Oct 21	msport Maryland	1 21795
BAITIM permit. Pa Departmen Importent: any Injury		21. Signature of Funeral Service Licensee 23a. Part 1. Enter the gissase, or complications that caused the death. Do not a	22. Name and Address of Facility Doug 1331 Eastern Blvd. N	glas A. Fiery Fi J. Hagerstown, M	neral Home
by Country are to executed which are to executed which are the burial-transit the burial-transit.	dical Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of): C. Due to (or as a consequence of): C. Due to (or as a consequence of):	ronic Reval / Mellitus on Atrial Fibrilla	luxe Failure Insulin	Interval Between
Hecords, P.O. Box 687 The law requires that the death certificate the has been signed by the attending physage 2 should be detached for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	B □Ectopic pregnancy 5 □ Other (specify)	23d. Date of o	delivery Day Year
ecords, P.O. By law requires that the death as been signed by the atter s 2 should be detached for	þ	Anoxie Sperable 1- nothing	underlying cause given in Part I.	23e. Did tobacco use contribute 1 Yes 2 No 3	
	e Completed	Anemia 25. Was case referred to medical		autopsy prior to death' 1 ☐ Yes 2 ☐ No 1 ☐ Ye	
on of ing Phys I. After this tuneral dii	ertification: To B	examiner? 1 Yes 2 Sets o Hospital: 1 Inpatient 2 ER/Outpat 27. Manner of Death 1 Sets of Injury (Month, Day Year) 2 Accident Investigation 2 Rospital: 2 ER/Outpat	ient 3 DOA Other: 4 Nursing Home of 28c. Injury at Work? M 1 Yes 2 No	5 Residence 6 Other (Sp. Describe how injury occurred	
DIVISIC ospitel or Attend hours after death unerel Director: ly filled in by the t	O	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify) 29a. Certifier (Check only (Check onl	ath occurred at the time, date and place, and o	Location (Street and Number or City or Town, State) due to the cause(s) and manner	as stated.
To the Hospitel To the Hospitel within 24 hours a To the Funerel I completely filled	Medical	one) and manner stated.			
5H-5		30 Name and address of person who completed cause of death (Item 23a) (Typ. TANVIR A. PASHA MI) 1122 G	D35497 e. Print) e. Print) e. Print)	STOWN, MZ	21740
St Regis	ate trar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1 4		

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygie pen [] [1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Elwood Thorton Sampson, Jr. October 15,2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Washington County Hospital Washington Hagerstown If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1**⊠**M 2□ F Director 218-50-3561 57 02/05/1947 PA Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location item 27 is marked other than "netural", or items 23a or 28a-f show other treumatic event, the Medical Examinat must be notified at 10d. Inside City Limits MD Hagerstown Washington Director 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? death with 14014 Marsh Pike US or items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? nours after 1 ☑ Never Married 2 ☐ Married ☐Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 Hygiene. other than "r Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Importent: if item 27 is marked other tha any injury or other treumatic event, Italy once. 12 Laborer General Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Elwood Thorton Sampson, Sr. Elizabeth Louise Revnolds 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Seth A. Sampson / Brother 3421 Great Lakes, Alexandria, VA 22306 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 □Donation 5 □ Other (Specify) Smithsburg Cremator. 10/17/2004 Smithsburg, MD 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service Licensee 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis /Medical Examiner Renal failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last Due to or as a consequence of): Examiner burial-transit NEUMONIE The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the ! IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐ Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 1 ☐ Yes 2 No 1 Yes To the Hospitel or Attending Physicien: " within 24 hours after death. To the Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 ☐ No 1 proatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00060396 DH. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1126 Opal Court Hagerstown Ma FARID nn WJUSHED 32. Registrar's Signature State Peller Registrar

		State of Maryland / Department of He Certificate of D	ealth and M Death		en 2 () () (34191
		Decedent's Name (First, Middle, Lest)		2. Dete of Deeth Month		3. Time of Death
	Physician /Medical	Charles Leonard SCHLEIGH		Oct.	15 2004	
)	Examiner	4b.	. City, Town, or Lo	cation of Deeth	4c. County of D	Peath
		Williamsport Nursing Home 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) If Under 1 Year	Williams	port	Washing	J
	Funeral Director	216-14-6694 1M 2 F 86 Yrs. Months Days	If Under 24 Hrs. Hours Min.	(Month, Dey,	Yeer) 3.	Birthplece (State or Foreign Country) Maryland
,		Usuel Residence of Decedent	1	пріді 5	1710	
-	show any	10a. Stete 10b. County 10c. City, Town or Location				10d. Inside City Limits 1 ☐ Yes 2X No
	or 28a-f s be notified Director	Maryland Washington Hagerstown 10e. Street end Number 10f. Zip Code		10	g. Citizen of Whet	
3	me 23e or 28e-f show I must be notified at nerai Director			10		Country
1	r fleme 23s	2007 Starlight Lane 21740		cify Yes or No-		merican Indian,
9	or items	1 □ Never Merried 2 □ Married 1 ☑ Yes 2 □ No □	, Mexican, Puerto I Specify:	Rican, etc.)		/hite, etc.
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717		Elementary/Secondary (0-12) College (1-4or 5+) 12 Clerk of Cour	rt	,	State Gov	zernment
and			18. Mother's Name			
a	Mentel Mentel Mentel artic eva	Frank Schleigh	Mabel B	arber		
Mar	E E	19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and	nd Number or Rure	Route Number,	City or Town, Stat	e, Zip Code)
é .	m 27 m 27 her to	Gary Schleigh - Son 17701 Meadowood 20a. Method of Disposition 20b. Place of Disposition (Neme of	od Drive		cown, Md.	
JOE J	nt: If Item	1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel from State cemetery, cremetory or other plece)	I const	555A0530A06	100	Gard 88 89
	artme ortant Injury	4 ☐Donetion 5 ☐Other (Specify) Rose Hill Cometery 21. Signature of Funeral Service Licensee 22. Name and Address	1 F			m, Maryland
מ	De la la la la la la la la la la la la la	James L. Jaioes 415 E. Wilso	· M.		uneral H town, Md	
		23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shoot, or heart failure. List only one cause on each line.	such as cardiac of	r respiratory arres	st,	Approximate Interval Between
	hysician					Onset and Death
	/Medical xaminer	Immediate Ceuse (Final disease or condition resulting in death) e. Congestive Heart F Due to (or as a consequence of): b. A there is clear to the content of the content	Failur	ع		months
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1	physician and the bunal-transit	Sequentially list conditions Due to (or es e consequence of):	Heart	Dise	are	years
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ָם פֿרי	been signed by the ettending p should be detached for use es leted by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	in Part I	23h Did toh	acco uso contrib	ute to the cause of death?
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ָר ע'	gned be de	Renal tailure				
ords, P.O	sen si sould	Renal Failure Hepatic Failure		24a. Was an performe		b. Were autopsy findings available prior to
	sata has been si paga 2 should Completed	repaire rarrare			TO THE OWN	completion of cause of death?
	cata l			‡∐ Yes	21-No	1 ☐ Yes 2 ☐ No
OI VICE	this certificata has ral director, paga 2: To Be Comp	examiner?	26. Place of Death			
5	orthis eral d	27. Manner of Deeth 28e. Date of Injury 28b. Time of 28c. Injury e	4 Light Nursing Hon	ne 5 □ Residen 8d. Describe how	ce 6 □Other (S	pecify)
	ation		es 2 No			
212	al Director: After to all Director: After to all Director: After to all in by the funera Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)	2	8f. Location (Stre City or Town,		Rural Route Number,
ם ב	rat Di					
2	within 24 hours after deeth. To the Funeral Director: After th completaly filled in by the funeral Medical Certification:	29a. Certifier (Check only one) 1 ★ Certifying Physician: To the best of my knowledge, death occurred at the time, (Check only one) 1 ★ Certifying Physician: To the best of my knowledge, death occurred at the time, one one of my knowledge, death occurred at the time, one of the physician in	, date end place, a nion, death occurre	nd due to the cau d at the time, date	ise(s) and manner e and place, and o	as stated. due to the cause(s)
4	vithin Fo the comple	29b. Signature end title of certifier 29c. License n	number	290	d. Date signed (Me	onth, Dey, Yeer)
	AB A	Cynthia Kuttner-Sands no D47	1451	0	ctober	15,2004
	2+LUA	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) CHATLIA KUTTHER - Sands MD 154 North A 31. Date filed (Month, Bay, Year) 32. Begistrer's Signature		31 - 11	13111000	som+
	9	Cynthia Kuttner-Sands MD 154 North A	rtizans	street	Mary	and 21795
	State Registrar	31. Date filed (Month, Day, Year) OCT 18 2004 32. Begistrer's Signature				
	negistiai	UUI 10 4004 Chateaux J. Branked				

State of Maryland / Department of Health and Mental Hygien 2004 34192 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** OCTOBER 2008 CLAIRE M. SETTA 8:15AMM /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner WILLIAM HILL MANOR EASTON TALBOT 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, JULY 6 Birthplace (State or Foreign Country)
 PA **Funeral** 1□ M 2 TF Months Days Hours Min 91 Yrs. Director 220-32-9521 Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f ahow 10d. Inside City Limits traumatic event, the Medical Exercitor must be notified at Director MD 1 X Yes 2 □ No TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö or items 23a 501 DUTCHMANS LANE 21601 Funeral AZU 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ZXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after innent of Health and Mental Hygiene. nent of Health and Mental Hygiene. ant: If item 27 ie marked other than "natural", or itei 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No þ 3 XWidowed 4 ☐ Divorced Specify: WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be GROVER LAWYER 2 ELIZABETH BUCKINGHAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra SUSAN L. GREENHALGH/DAUGHTER 6360 BELLEVUE RD, ROYAL OAK, MD 21662 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State * 4 □ Donation 5 □ Other (Specify) SPRING HILL CEMETERY 10-6-2004 EASTON, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 JOHN MERCERO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Draw Stem Var **Physician** ZWREA /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner and Il-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial Box 68760. Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetel death 23b. Was decedent pregnant in the past 12 months?
1 \(\text{Yes} \) 2 \(\text{Yes} \) 23d. Date of delivery 3 Ectopic pregnancy Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a detached f Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cayse given in Part I. 23e. Did tobacco use ___ tribute to the cause of death? 2 No 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed?/ Division of Vital 1 Yes 2 No 25. Was case referred to medical examiner? 26. Plage of Death (Check only one) Other: 4 Nursing Home 1 ☐ Yes / 2 ☐ No 1 Inpatient 2 ER/Outpatient Certification: To 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Whatural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fi death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Surcide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of sertifier 29c. License number 29d. Date signed (Month, Day, Year) 1008 715 clain 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM H. WOOD, JR. M.D. 501 DUTCHMANS LANE EASTON, MD 21601 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 0 5 2004 Registrar

lmeno	led,#31	, RE	State of Maryland / Department of Health and N	lental Hygie	2004	34193
			Registrar 1. Decedent's Name (First, Middle, Last)	Reg. 2. Date of Death	No.	3. Time of Death
	Physici /Medi		EDWINA J. SEYMOUR	Month Oct 7	Day Year 7 2004	12:35 A ^M
	Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death	
			Genesis ElderCare - The Pines Easton 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year I funder 24 Hrs.	8. Date of Birth	Talbot	
	Funeral Director		1 M 2 XF Vrs Months Days Hours Min.	(Month, Day, Yes		place (State or Foreign ntry) RYLAND
	aryland show	<u>-</u>	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	r 28a-f	Director	MD TALBOT EASTON 10e. Street and Number 10f. Zip Code	10g.	Citizen of What Cour	1X Yes 2 No ntry?
	23a o	aiD	610 DUTCHMANS LANE 21601		USA	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Menial Hygiene. Itam 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic event, the Medical Evantrat must be rodified at	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes, Give 1 □ Yes 2 ▼ No Specify: 13. Was Decedent of Hispanic Origin? (Spe if Yes, specify Cuban, Mexican, Puerto 1 □ Yes, Give 1 □ Yes 2 ▼ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: WH]	etc.
21215-0036	natura	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work)	ing 16b	b. Kind of Business/In	dustry
12	2 should be filed withir and Mental Hygiene. Is marked othar than aumatic evant, the Ms	dmo	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired) 11 0 HOMEMAKER		OWN HOME	
	buld be filed Mental Hygi arked othar atic evant, I	Be C		(First, Middle, Maid		
Seymour	2 should t and Ment is marked aumatic	10	EDWARD L. JAMES LUCRETIA			
Se	and 2 sho ealth and n 27 is m		19a. Informant's Name/Relationship (Type, Print) NANCY S. MATTHEWS/DAUGHTER PO BOX 190 CORDOVA, I		ity or Town, State, Zip	(Code)
Edwina Baltimore,	0 0			Date 20c	. Location - City or To	
id W	permit. Pages Department of Important: If it any Injury or c		21. Signature of Funeral Service Licensee 22. Name and Address of Facility		STEVENSVI	
	20729		Joseph M. Oshush C.f. S. FELLOWS, HELFENBEIN 200 S. HARRISON ST J	EASTON. M	D_21601	
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	r respiratory arrest,		Approximate Interval Between Onget and Death
,092	Medical Examiner Asician and burial-transit	Ical Examiner	Due tr (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):			
P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funaral Diractor: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) 9 Unknown 5 Other (specify) 1 1 1 1 1 1 1 1 1		23d. Date of delive Month	ery Day Year
	v requires that been signed b should be dete	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	co use contribute to the	ne cause of death?
Vital Records,	The taw requiate has been page 2 should	Completed	Congressive heart failure	24a. Was an autopsy performed	prior to cor death?	psy findings available impletion of cause of 2 No
Vita	ysician: The is certificate hadirector, page	Be	25. Was case referred to medical examiner? Hospital: Other: Other:			
of	ng Phys ter this neral dir	.: To	27. Magaer of Death 28a. Date of Injury 28b. Time of 28c. Injury at 2	ne 5 Residence	6 Other (Specify	')
ion	ttending Ph death. ctor: After th y the funeral	ation	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No			
Division	tal or Atters after de al Diracto	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, St.	and Number or Rura ate)	l Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the cause ed at the time, date a	e(s) and manner as st and place, and due to	ated. the cause(s)
	with To t	Z	29b. Signature and title of certifier WD 29c. License number D 3 5 7 3 0	29d. I	Date signed (Month,)	Jay, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBLERT SANCHEZ, MD 508 TOLEWILD AVE	-ASTON 1	ms 218	66/
	Sta Registr		31. Date filed (Month, Day, Year) 32 Registrar's Signature OCT 07 2004	Beau	1. Span	40

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State of Maryland / Depart	tment of Health	and Mental H	voiene 2 n n

Department of Health and Mental Hygiene 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Leother Strong October 10,2004 7:27 AM /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Prince George's Community Hospital Cheverly Prince George's If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 64 Yrs. 1 2 M 2 □ F 579-54-8144 Director Dec.1,1939 North Carolina Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or Itams 23a or 28e-f show other treumatic event, the Modical Exemine must be redified at 1X Yes 2 No Directo Prince George's Landover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5200 Flintridge Drive 20784 USA Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: ģ 3 ☐ Widowed 4 ☒ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) 11 Building Maintenance Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be finent of Health and Mental I ant: If item 27 is marked o Unavailable Argie Lee Strong 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) parlment of Health a sortant: If item 27 is / injury or other treu Kathleen A. Hawkins - Daughter 502 21st Street, NE, Washington, DC 20002 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Durial 12 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. 4 ☑ Donation 5 ☐ Other (Specify) Strong-Bland Cem. 10-16-04 Vanceboro, N.C. ignature of Aneral Service Leepsee 22. Name and Address of Facility Latney's Funeral Home 3831 Georgia Ave., NW, Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) mmundationcy Physician /Medical Due to (or as a consequence of): **Examiner** B-cell (ymphoma if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medicai for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records. paeumonia 1 Yes 2 No 3 Probably 4 Unknown Completed nilure 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 has Clostridium 1 Yes 2 No Division of Vital or Attending Physicien: 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ဥ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 11 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A 2 Accident the 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and fitte of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10/10/04 mee 00043662 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Boyce PG (tosp 3001 Hospital Road, Cheverly, Md. 20785 31. Date filed (Month, Day, Year) . Registrar's Signature-State 1 4 2004

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier

1. 31.105

			1 - State Registrar		C	ertificate of	Death	,	Reg. No.	J U 4	34133	
	Physici		Decedent's Name (First, Middle, SYLVIA	·	ITH			2. Date of De Month OCTOBE	ath	2004	3. Time of Death 3:55 PM	
	/Medi Examir		4a. Facility Name (If not institution,			4b. City, Town,	or Location of Death	·		ounty of Death		
П	LXaiiiii	CI	HEBREW HOME OF G	REATER WASI	HINGTON	ROCKVII				TGOMERY		
	Funeral			6. Sex 7. Ag	ge (In yrs. last birthda		r If Under 24 Hrs.	8. Date of Bir	h		nplace (State or Foreig	
	Director		054-09-9338 Usual Residence of Decedent	1□M 2 X F	87 Yrs.	World a Days	s riodis iviiri.	12/26/	1916	NEW	YORK	
	yland		10a. State 10b. County		10c. City, Town or	Location					10d. Inside City Limits	
	B Mar	ctor	MARYLAND MONTGOM	IERY	ROCKVILL	E					1X Yes 2 ☐ No	
	ith th	Oire	10e. Street and Number			10f. Zip Code			10g. Citize	n of What Cou	intry?	
	ath w	ral	6121 MONTROSE RO	AD		20852			U.:	S.A.		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itema 23a or 28a-f show any injury or pthar traumatic evant, The Medical Evantment must be notified at once.	by Fune	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? d 1 ☐ Yes 2 X If Yes, Give Year or Dates:	?	If Yes, specify Cu	Vas Decedent of Hispanic Origin? (Specify Yes or No- Yes, specify Cuban, Mexican, Puerlo Rican, etc.) ☐ Yes 2 No Specify:			14. Race - American Ind Black, White, etc. Specify: WHIT		
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lar	2 sho		19a. Informant's Name/Relationship				at and Number or Ru					
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altimore,	Pages nent of H		1 ☑ Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spe			ematory or other pla	ace)	/2004		tion - City or T		
Balt	permit. Departr Imports any inje		21. Signature of Funeral Service Lie	Sudaliza-	D 1	22. Name and Addr ANZANSKY – 170 ROCKV	ess of Facility GOLDBERG ILLE PIKE	MEMORIA	L CHAI	PELS, I	INC.	
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that cause nly one cause on each l	d the death. Do not e	nter the mode of dy	ing, such as cardiac	or respiratory ar	rest,		Approximate Interval Between	
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ono	ding Ph th. After thi funeral	tlon:	1 tural 5 Pending	28a. Date of Inju (Month, Da	ury 28b. Time ly Year) Injury	Wo	ork? □Yes 2 □No	28d. Describe h	ow injury o	ccurred		

To the Hospital or Attand within 24 hours after death To the Funaral Diractor: A completely filled in by the fi Medical Certifica 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D55258 30, Name and address operson who completed cause of death (Item 23a) (Type, Print) B. Wilks, mD ROAD 31. Date filed (Month, Day, Year)
OCT 13 2004 32 Registrar's Signature State Registrar DHMH 17 Rev 1/2001

			1 - For State Registrar	State of M	aryland	-	artment rtificate			and M		Reg. No.	200	4	34	196
Н	Physici	an	1. Decedent's Name (First, Middle, La Frank J. Schaff								2. Date of Dea Month Octobe:	Day	2004	ar	3. Time of 2:15	Death PM
	/Medic		4a. Facility Name (If not institution, gir		r)		4b. City, To	own, or	Location o	of Death	00000		County of [2.13	1
	Examin	ier	509 Leighton Av		,				r Spr					tgome	erv	
	Funeral		5. Social Security Number 6.	Sex 7. A	Age (In yrs. las	it birthday)	If Under 1		If Under 2		8. Date of Birt (Month, Da	h Vearl	9.	Birthola	ce (State of	r Foreign
	Director		220 11 2001	1 ⊊ M 2□F	92	Yrs.	Months	Days	Hours	win.	July 13	, 19	12 1	Country New	York	
	and **		Usual Residence of Decedent 10a, State 10b, County		10c. City,	Town or Lo	cation							100	I. Inside Cit	y Limits
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	28a	rec	10e. Street and Number	JOINE 1 7			10f. Zip C					10g. Citiz	en of Wha	t Country	/?	
	h with	Funeral Director	509 Leighton Ave	enue			209	901					USA			
	deat deat	ner	11. Marital Status	12. Was Deceder Armed Forces	nt Ever in U.S.	13.	Was Decede	ent of His	spanic Orig	gin? (Spe	cify Yes or No Rican, etc.)	. 1	4. Race - A	Americar White, et		
36	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. I them them 27 is marked other than "natural; or items 23e or 28e-f show other traumatic event, if a Medical Examinal main the indifficular	by Fu	1 ☐ Never Married 2 € Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀	∂ No	1	1□ Yes 2		Specify:					Whit		
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Maryland	2 shd and Is m		19a. Informant's Name/Relationship								Route Number					
	and and Health		Frieda Schaffer/ 20a. Method of Disposition	wile	20b. Pla		sition (Name		venu		ilver S		ation - Cit			
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8760,	be executed by executed by the death certificate be executed by attending physician and derive as the burial-transit	Ical Examiner	shock, or heart failure. List ont Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	aR.cal Due to (or a b. Con les Due to (or a	Failur as a conseque Stive E as a conseque	ence of): Ieart ence of): Tac	Failu chycar								Mont	hs
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Division		Certification;	3 Suicide 6 Could not determine	286. Place of	Injury - At horr etc. (Specify)	ne, farm, st	reet, factory,	, office			28f. Location (i City or To		d Number (or Aural I	Route Num	ber,
	To the Hospital or within 24 hours afte To the Funerel Dir completely filled in	edical (Physician: To the be aminer: On the basis and manner	s of examination)
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	0		30. Name and address of person who Ira Tauber, M.D.					Silve	er Sp	ring	, MD 20	902				
	St Regist	ate rar	31. Date filed (Month, Day, Year) OCT 12 2	32. Regi	istrar's Signatu	Jre &	Spo	uks	/							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygier 20 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** OCTOBER 9, Louis G. Shirey 2004 2:40A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** VA MARYLAND HEALTH CARE SYSTEM PERRY POINT CECIL 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours 1⊠M 2□F Director 70 212-30-5898 July 24,1934 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov traumatic avant, the Medical Examinar trust be putilized at MD Harford Havre de Grace Director 1 TYes 2X No the 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 100 Revolution Street 21078 or items 23a USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: Specify: 1 ☐ Yes 2 X No ģ White Specify: 3 Widowed 4 Divorced 'natural', Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Auto 12 markad othar ulth and Mental Hyuris mark-17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Vernon H. Shirey India Boxer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ages 1 and 2 nt of Health a Irene Wisch/Sister 8003 Woodholme Circle, Pasadena, MD othar 1 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite 1 Burial 2 Cremation 3 Removal from State Oct. 11, Metro Crematory ` 4 □ Donation = 5 □ Other (Specify) Baltimore, MD 2004 21. Signature of Fun-rai Service Licenses 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home e. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Actionly one cause on each line. 21146 23a Part1. Enter the disease shock, or beart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PNEUMONIA UNKNOWN /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to influediate cause. Enter Underlying Cause (Disease or injury that influed events resulting in death) Last Due to (or as a consequence or, Examine The law requires that the death certificate be executed Due to (or as a consequence of): physician a s the burial-t Box 68760 Physician/Medical attending properties of IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗌 Yes 2 **X**No 1 Tyes 2 No of Vital To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 2 1 ☐ Yes 2X No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred Division 5 Pending Injury 1 🗆 **X**atural 1 ☐ Yes 2 ☐ No 2 Accident investigation Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours are To tha Funaral Dir 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D52739 OCTOBER 9, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURESH SHANDELYA, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MARYLAND 21902 31. Date filed (Month, Day, Year) astrar's Signature State Registrar

DHMH 17 Rev 1/2001

Amended	,	#	26	,
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	Physici		KATHRYNA RA	Y STET	SON				OCTOBE			MA0080		
	/Medic Examin		4a. Facility Name (If not institution, gi	e street and number	r)	4b. City, To	own, or Lo	cation of Deal	th	4c.	. County of Death	1		
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	Funeral				Age (In yrs. last birthda	y) If Under 1 Months I		Under 24 Hrs Hours Min		rth ay, Year)	9. Birth Cou	place (State or Foreign Intry)		
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	with a or .									rog. o		,		
	eath	era	PO BOX 1190	12. Was Decede	nt Ever in U.S. 1		3475	anic Origin? (5	Specify Yes or N	0-	USA 14. Race - Amer	ican Indian,		
36	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is markad other than "natural; or Items 23a or 28a-f show other traumatic event, the Modical Exercities must be rediffed at	by Funeral	1 Never Married 2 Married	Armed Force 1 ☐ Yes 22 If Yes, Give] No	If Yes, specify		Mexican, Puèr Specify:	Specify Yes or N to Rican, etc.)		Black, White Specify: WI	, etc. HTE		
21215-0036	hours lural	다 다	3 Widowed 4 Divorced 15. Decedent's 8	Year or Date		cedent's Usual	Occupation	20			ind of Business/I	ndustry		
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Maryland	should and Menion Menio	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Ma	iling Address (Street and	Number or R	ural Route Numi	ber, City o	or Town, State, Z.	ip Code)		
	1 and 2 Health a em 27 ls		RYCKMAN R. WALBE	RIDGE/SON	71	7 E. HI	GH S'	T POTTS	STOWN, P	A 19	464			
ē,	s 1 a of Hear Item othe		20a. Method of Disposition		20b. Place of Dis	position (Name rematory or oth	er place)		Date	20c. L	ocation - City or T	Town, State		
Ĕ	Pages ment of tant: If It		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Control of Cont		CHESAPE	AKE CRE	ITAM	ONCTR	10-4-20	04 S	TEVENSV1	ILLE, MD		
Baltimore,	permit. Pag Department Important: any injury once.		21. Signature of Funeral Service Lice	MAM	FUNERAL	HOME PA								
			23a. Part1. Enter the disease, or conshock, or heart failure. List ont	mplications that cause		enter the mode	of dying, s	such as cardia	EASTON	arrest,	21001	Approximate		
	-	ŭ.	Immediate Cause (Final									Interval Between Onset and Death 3 M IN ThS		
ı	Physician /Medical		disease or condition resulting in death)		static DVa	TUN CA	nai					3 MININS		
	Examiner			·										
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	ng ph	V/Medical	IF FEMALE:		Charles and Princip									
Вох		_	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No		2 Fetal death	3 □Ectopic prec	gnancy cify)				23d. Date of deli- Month	very Day Year		
P.O.	at the de by the a	Physicia	9 Unknown	9□ Unknow	1									
	de de	y P	Part II. Other significant conditions		n but not resulting in the	underlying cau	use given i	in Part I.	23e. Did	tobacco	use contribute to	the cause of death?		
rds	quires in sign uld be	Pa P	breast cance	<i>r</i>					1 🗆	Yes 2	No 3□Pro	bably 4 Dunknown		
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Re	The lav	E							auto peri 1 🗌 Yes	ormed? 2 No	death?	200 No		
tal		0	25. Was case referred to medical				2	6. Place of De	eath (Check only					
<u>=</u>	Physician: this certificantal director.	To B	examiner? 1 □ Yes 2 □ No	Hospital: 1 ☐ Inp	atient 2 ER/Outpa	ient 3 DOA	Other:	4 Nursing	Hom 5	-senec	Other (Spec	Sammer iv) resident		
	ding Ph h. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigate	28a. Date of I (Month,	njury 28b. Timo Day Year) Injur		c. Injury at Work? 1 🗆 Yes	t s 2 □No	28d. Describe	how inju	occurred			
Division	To the Hospital or Attanding Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funera	Certification:	3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of	Injury - At home, farm, etc. (Specify)						ral Route Number,			
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	thin 2 the the mplet	Med	one) 29b. Signature and title of certifier	and manner	Stateu.	29c.	License n	umber		29d. Da	ite signed (Month	. Day, Year)		
	7. W 0.0	_	Matthew Fr	sike M.	D			5225	= /		14/04			

State Registrar 31. Date filed (Month, Day, Year) OCT 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MATTHEW FISCHER MD 2 Martin (out Sutt) 32. Registrar's Signature

Caston Maydend

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 20b per fb e836-10-27-04 vt.

		1 - State Registrar	State of Maryland	Y Depa	tiffment of H	lealth and I Death		2004	34199
Physic		Decedent's Name (First, Middle, Last) Anna LaVerne					2. Date of Death Month	Day Year 20 20 4	3. Time of Death '
/Med Exam		4a. Fecility Name (If not institution, give s 34 LaVale Blvd			4b. City, Town, or LaVale	Location of Death	1	4c. County of Deat	h
Funera Directo			7. Age (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 12-24-	Year) 9. Birti	hplace (State or Foreign untry) Savage MI
e Maryland te-f show	ctor	Usual Residence of Decedent		Town or Lo Vale	cation				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
with th	i Dire	10e. Street and Number 34 LaVale Blv			10f. Zip Code 21502			g. Citizen of What Co	untry?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neture!", or items 23e or 28e-f show any injury or other treumetic event, the Madical Experimental be notified at	by Funerai Director		12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:	1	Vas Decedent of H Yes, specify Cuba	_		14. Race - Ame Black, White	
21215-0036 d within 72 hours af giene. er then "neturel", or the Madical Experi	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation	(Give life. L	ent's Usual Occupa kind of work done of NOT use retired	during most of work	ing 16	6b. Kind of Business/l	Industry
nd 2	Be Co	17. Father's Name (First, Middle, Last)		36	Crecary		e (First, Middle, Ma	Clerica	L
Maryland 1d 2 should be file 1th and Mental Hy 27 Is marked oth	101	Ralph Lashley 19a. Informant's Name/Relationship (Ty)	ne Print)	19h Mailin	a Address (Street	Minnie		in) City or Town, State, Z	in Code)
and 2 satth an n 27 Is		Martha Fadeley	- Admn.	32	LaVale	Blvd.,	LaVale,	MD 2150	
Baltimore, permit. Pages 1 ar Department of Hea Importent: If item any injury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Lav	netery, cren Lawn	sition (Name of patory or other plac Mem Gar	10-2	2-04 La	aVale, MI)
Dermit Depar Impor		21. S ture of Funeral Service License	Hope		Name and Address Name 1302 Na	tional	Hwy., La	aVale, M	rvice, PA D 21502
Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	ATI	12:220	AND DOMEST	or respiratory arres		Approximate Interval Between Onset and Death
bb / bu, licate be executed physician and is the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque						
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Kords, P. Wrequires that been signed by should be deta	Ď	Part II. Other significant conditions con	tributing to death but not result	ing in the un	derlying cause give	en in Part I.		cco use contribute to	
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dling I		27. Manner of Death 1 ──Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Yeer)	Bb. Time of Injury	28c. Injury Work M 1 🗆 \	at :? ∕es 2 □ No	28d. Describe how	injury occurred	
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Lo the Hospitel Within 24 hours a Within 24 hours a Completely tilled	edical	29a. Certifier 1 Certifying Phys (Check only 2 Medicel Examinone)	icien: To the best of my knowler: On the basis of examinatio and manner stated.	edge, death n and/or inv	occurred at the timestigation, in my op	e, date and place, pinion, death occur	and due to the caused at the time, date	se(s) and manner as and place, and due to	stated. o the cause(s)
To the within ?	Ne S	29b. Signature and title of certifier	-119		29c. License	number	29d	. Date signed (Month,	Day, Year)
		30. Name and address of person who co	mpleted cause of death (Item 2	3a) (Type, F	Print)	54001	1 1/0	1.21-04	/
		Shir Khanna	32. Registrar's Signatur	Vation	nal Aligher	on La Va	le, MI)2/502	
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	Physicia	20	1. Decedent's Name (First, Middle, Last)						2. Date of Dea Month	th Day	Year	3. Time of Death
	/Medic		WILLARD LEE T	'AGGART	, JR	•			OCTOBER	21,20)04	2:38P. M
	Examin	er	4a. Facility Name (If not institution, give str UNIVERSITY HOSPITA		er)		4b. City, Town, or BALTIM	Location of Death		4c. County	of Death	
	Funeral		5. Social Security Number 6. Sex		Age (In)	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	9. Birth	place (State or Foreign
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	with Sa or						21921		,			
	deeth ma 2;	Funeral	33 LOVELAND DRIVE	. Was Decede	ent Ever i	in U.S. 13. \	Was Decedent of H	spanic Origin? (Sp	ecify Yes or No-		ED ST	can Indian,
0	or ite		1 ☐ Never Married 2 🔀 Married	Armed Force	os? □Nol9	952-		n, Mexican, Puerto	Rican, etc.)		ck, White,	etc.
2	filed within 72 hours after deeth with the Maryland Hygiene. Ather than "natural", or Itema 23a or 28a-f show ant, the Medical Eastrill or Item Let Indiffied ut	1 by	3 Widowed 4 Divorced	If Yes, Give Year or Date	s: 19	955	1 □ Yes 2 汉 No	Specify:		Specif	WH.	ITE
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ָב ב			20a. Method of Disposition		20	b. Place of Dispo	sition (Name of		BER 25,	20c. Location -		
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	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee			22 H.	Name and Addres	s of Facility FOR FUNE	ERALS, P			
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	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	(1)	alti		WISES					
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3	or A after Direc in by	Certification:	4 Homicide determined	building	etc. (Sp	- /	еет, тастогу, опісе С		City or Towr	, State) Buc	FBAIL /	Rund Admin
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	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	edical	(Check only 2 Medical Examine		s of exan							
	To the To the Comp	ž	29b. Signature and title of certifier	1 1	-/	_	29c. License	number	2	9d. Date signer	d (Month,	Day, Year)
) YM	1. /			0	.C.M.E.	α	CTOBER	22,20	004
			30. Name and address of person who com		_		·	Ctmot F)a]+ima-	o Moss	ol and	21201
	Sta	to	JACK W. T. 31. Date filed (Month, Park Year)		istrar's Si		TIT LEIN	Street, E	иттиЮП	e, mary	Tarki	~14U1
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State of Maryland / Department of Health and Mental Hygiege 0 0 4 34201 State Registra MEND ITEM #23b PER PHY G836 GET TO PROBLEM OF THE PER PHY G836 GET TO PROBLEM OF THE PHY C836 GET TO PROBLEM Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last, June 20, 2004 **Physician** Mary Elizabeth Tawney 11:10p м /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Prince Frederick Calvert Calvert Memorial Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min 8. Date of Birth (Month, Day, Year) July 26,1910 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 💆 F 93 Maryland Director 577-07-3668 Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f shov traumetic event, the Wedical Examiner must be notified at 1 XYes 2 ☐ No North Beach Calvert Directo Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5 20714 U.S.A. 3903 5th Street Items 23e Completed by Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Instit of Health and Mental Hygiene. 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Specify: 3 X Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) switchboard operator retail store 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hall Nellie Sanford Samuel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) St., North Beach, MD 20714 Joseph T. Tawney, II, son other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State ō Department of Importent: If any injury or once. Washington National 06/24/2004 Suitland, MD `4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen-22. Name and Address of Facility Rausch Funeral Home P.A., Owings, MD 20736 ectail 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Examiner Lecurrent Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown Š signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 1 🗌 Yes certificate Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Rehabilla 1 ☐ Yes 2 No 2 this 27, Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 TSuicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier Scrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the ! the 29d. Date signed (Month. Day, Year) 29c. License number 2 0027189 OL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Solomons Isl. Rd. - Huntingtown Md. 20639 40USA+ 32. Registra Signature State 2004 Registrar

1- State of Manufand / Department of Health and Mental Hygie (1) La Ragistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Velma Robinson 8, - Vassel October 2004 7:55 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Dec. 25, 19 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 1 □ F 45 Yrs. 578-19-2103 Dec. Jamaica Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or Items 23e or 28e-1 show the Modical Examiner must be notified at 1 ☐ Yes 2 No Completed by Funeral Director Maryland Montgomery Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1107 Holton Lane 20912 USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: Black Maryland 21215-0036 1 ☐ Yes 2 HNo 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry i Hygiene. other then ' College (1-4or 5+) Elementary/Secondary (0-12) Bank Teller Banking permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygies Importent: If them 27 is marked other thany Injury or other traumatic event. In once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Herman E. Robinson Rona M. Myrie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jonas Vassel/ Husband 1107 Holton Lane. Takoma Park. MD 20912 Baltimore, 20b. Place of Disposition (Name of cametery, cramatory or other place)
Gate Of Heaven 20a. Method of Disposition October 15, 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2004 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 21. Signatura of Juneral Service License Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, 0104 MD 20901 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RESPIRATORY FAILURE ACUTE 3 DAYS Physician /Medical Due to (or as a consequence of): Examiner FIBROSIS YLMONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner rsician and e burial-transit SYSTEMIC ERYTHEMATOSIS LUPUS Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9□ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital Hospitel or Attending Physiclen: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 7 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification; After 1 Natural Injury 5 Pending within 24 hours arren comments. To the Funerel Director: A М 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Textifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Joseph B. Muzgerd, M.D. 00008425 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 CARROLL AVE. JOSEPH MIZGERD TAKOMA PARK MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 12 2004 OCT Registrar

State of Maryland / Department of Health and Mental Hygiene 11

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29b. Signature and title of certifier 29c. License number 29d. D47234	9d. Date signed (Month, Day, Year)

Physician /Medical Examiner 1. Decedent's Name (First, Middle, Last) Charles H. Watts Charles H. Watts 4a. Facility Name (If not institution, give street and number) Clinton Nursing & Rehab. Center Clinton Nursing & Rehab. Center Clinton Nursing & Rehab. Center Clinton Nursing & Rehab. Center Clinton Nursing & Rehab. Center Clinton Nursing & Rehab. Center Clinton Nursing & Rehab. Center S. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months) Months Days Hours Min. Jan. 7, 1914 Wash. D.C. Usual Residence of Decedent 10a. State 10b. County Maryland Prince Georges Temple Hills 10c. City, Town or Location 10d. Inside City Limits Wash. Do.C. 10d. Inside City Limits Wash. Do.C. 10d. Inside City Limits Wash. Do.C. 11d. Race - American Indian, Black, White, etc.			-	For State Registrar AMEND#20bperFF	State of Ma 110/14/04,BM	aryland / D I,MbCo (epartr <i>Certifi</i>	nent of Ho cate of D	ealth and Death	Mental H	ygien Reg. N		34204
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Physician // Medical Examiner Page Physician / Medical Examiner Page P				23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lir	the death. Do n							Interval Between
Coronary Artery Disease Due to (or as a consequence of): Chronic Renal Failure 1 yr. Chronic Renal Failure 1 yr. Chronic Renal Failure 1 yr. Chronic Renal Failure 1 yr. Chronic Renal Failure 23d. Date of delivery Morth Day Year of Delivery Morth Day Year of Delivery Morth Day Year of Delivery Morth Day Year of Delivery Morth Day Year of Delivery Morth Day Year of Delivery Deli				disease or condition				ailure					
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The second of th	^	al-tran	хап	that initiated events resulting in death) Last	G.			ure					ı yı.
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Part Part	rds	quires in sigr uld be								1 [Yes 2	2 X No 3□P	robably 4 Unknown
Part Part	900	aw re	piet									24b. Were a	utopsy findings available
26. Place of Death (Check only one) 27. Manner of Death 1	Ä	The ate h page	Com							pe	rformed?	death?	
27. Manner of Death 1 Matural 2	/ita	cian: ertific	O	examiner?	Hospital:			Othe					
1 Matural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined 29a. Certifier 29a. Certifier City or Town, State) 29a. Certifier City or Town, State) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 32 Registrar's Signature 31. Date filled (Month, Day, Year) 32. Date filled (Month, Day, Year) 32. Date filled (Month, Day, Year) 32. Date filled (Month, Day, Year) 32. Date filled (Month, Day, Year) 32. Date filled (Month, Day, Year) 32. Date filled (Month, Day, Year) 32. Date filled (Month, Day, Year)	of \	Physi this c	\vdash		1 _ Inpatie			DOA	4A Inursing				ecify)
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	Physicia		1. Decedent's Name (First, Middle Hoven Ce I		er		-				2. Date of Month		Day	Year 2004	3. Time of Death
}	/Medic Examin		4a. Facility Name (If not institution				4b. City,	Town, or	Location	of Death		j	4c. Count	-	
			HEBREW HOM	E				RO	CKVII	LLE			1	MONTO	GOMERY
	Funeral Director		5. Social Security Number 578–18–7171	6. Sex 1 ☐ M 2 X		s. last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of (Month NOV .	Birth Day, 1	^(ear) 1912	9. Birti Co MAI	nplace (State or Foreign untry) RYLAND
	pur *		Usual Residence of Decedent 10a. State 10b. County		10c C	ity. Town or Lo	ncation								10d. Inside City Limits
	sho	5		WEDW.	133.13	,,, , , , , , , , , , , , , , , , , ,		DOOR		_					1 XYes 2 No
	the A	Director	MD. MONTGO	MEKY			10f, Zip		VILLI	\$		100	. Citizen of	What Co	
	with a or			ROSE RD.			TOI. Zip		852			100			
	ns 23	Funerai	11. Marital Status		Decedent Ever in	U.S. 13. 1	Was Deced			igin? (Sp	ecity Yes o	No-		J.S.A	ncan Indian.
10	r Itan	표	1 Never Married 2 Marri	Armed	Forces?				n, Mexicar	n, Puerto	ecify Yes or Rican, etc.)		ck, White	
8	urs a	þ	3 XWidowed 4 ☐ Divorced	JI Y OS.	Give A or Dates:		1 🗌 Yes	2 XNo	Specify:				Specif	y: WI	HITE
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or Itams 23e or 28e-f show event, If a Medical Examination is intelliged.	Completed	15. Decedent (Specify only highes	s Education	ad)	16a. Dece	dent's Usua kind of wo	al Occupa	ation	t of word	ina	16	6b. Kind of B		
218	within 7 ene. than *r	ple	Elementary/Secondary (0-12)	Ť	e (1-4or 5+)	life.	DO NOT us	se retired,)	t of work	ang				
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<u>yla</u>	Ment Ment arke	ပ	DAVID	L.	HORST						1ARY		DEITR1		
Maryland	2 should be and Mental ls marked (6.5	19a. Informant's Name/Relationsh		_	1.							City or Town		ip Code)
2	and ealth m 27		DOROTHY WHEELI	ER DOYLE	·				T., J		_	-	. 2175		
Ore	OF THE		20a. Method of Disposition 1 Burial 2 Tremation	3 Removal fr	4	Place of Dispo cemetery, cren	natory or o	ne of ther place	9)		Date	20	c. Location	- City or	Town, State
Ë	men tant: jury		*4 □ Donation 5 □ Other (Sp			CHAMBE	RS CR	EMAT(ORY 1	0-12	2-2004		RIVERI	ALE,	MD.
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic every.		21. Signature of Funeral Service	umlu	MOC MOC	CI	2. Name an HAMBE 801 C	RS F	UNERA	L HO	OME &	CRE ERD	MATORI ALE, M	UM, E	P.A. 20737
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications th	at caused the dea										Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. F	neuma	onia									Onset and Death
	/Medical		resulting in death)	Due	to (or as a conse	equence of):				(
	Examiner		Sequentially list conditions	b	lostridi	ium c	liffic	ule	Co	itis					9/23/04
Į.	D #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due	to (or as a conse	equence of):									
	and trans	am	Cause (Disease or injury that initiated events resulting in death) Last	c											
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8760,	cate be executed obysician and the burial-transit	dicai		d											
9 xo	n certific inding p use as	Physician/Me	IF FEMALE:	23c If yes	outcome of pregr	nancy									
Bo	ath or	ian	23b. Was decedent pregnant in the past 12 months?	1 Li	ve birth 2 Fel	tal death 3 🗆	Ectopic pro Other (sp							te of deli onth	very Day Year
o.	that the de ed by the a detached t	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	Towns .	nknown	Geath 5	J Otner (sp	өспу)							
0	res that tigned by	h h	Part II. Other significant condition	ns contributing t	o death but not re	sulting in the u	nderlying c	ause give	n in Part I		23e. D	id toba	cco use conf	ribute to	the cause of death?
ds,	89 G 99	d by					, ,	•			1	☐ Yes	2 X No	3 Pro	bably 4 Unknown
ecords,	w requir been si should	lete									24a. W	hoan	245	Mora au	anny findings available
Re	e lar has	Completed									a	ras an utopsy erforme	1	prior to c death?	opsy findings available ompletion of cause of
<u>a</u>	(0)		25. Was case referred to medical									s 2			2 🗆 No
Division of Vital	Physician: r this certific ral director.	o Be	examiner? 1 Yes 2 No	Hospital:	☐ Inpatient 2[_ ☐ ER/Outpatien		Othe			h (Check on		- 50		5.7
of	Phys	-	27. Manner of Death	28a. Da	ate of Injury	28b. Time of		8c. Injury Work	4/2 140				injury occur		ify)
on	nding th. th. : After s funer	tlor	1 ⊠ (Vatural 5 ☐ Pending 2 ☐ Accident investig	(A	fonth, Day Year)	Injury	М		? ′es 2 🗆						
/isi	or Attending after death. Director: Aftel in by the fune	ifica	3 ☐ Suicide 6 ☐ Could r	200. FI	ace of Injury - At I	home, larm, str	eet, factory	, office						er or Ru	ral Route Number,
á	al or A after I Dire d in by	Certification:	4 Homicide	be	uilding, etc. (Spec	city)					City or	Town, S	State)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1, Certifyin	Physician: To	the best of my kr	nowledge, death	occurred :	at the tim	e, date an	d place,	and due to t	he caus	se(s) and ma	anner as	stated.
	n 24 he Fu he Fu	edical	one) 2 Medical i	xaminer: On the	e basis of examination	nation and/or inv	estigation,	in my op	inion, dea	th occur	red at the tin	ne, date	and place,	eub bns	to the cause(s)
	With To t	Σ	29b. Signature and title of certifier	a				. License					. Date signe		
)			> Shilpa H	anun	mo		D	0002	-713			10	A11,	20	04
	5		30. Name and address of person of Shilpa H. A	who completed o	ause of death (Ite	эт 23a) (Туре, 21 Мо	Print)			,	Pocki	ille	, mo	2018	17
	Sta	te	31. Date liled (Month, Day, Year)	33	2. Registrar's Sign		Spa								
1	Registr	ar	OCT 13	2004	General	13	Ripo	ins!							

Florance H. Wheeler

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra 34206 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Yeer 10:50 AM KONARD OCTOBER WOLF 10 2004 /Medical 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) 4c. County of Deeth **Examiner** HOSPITA WASHINGTON DUENTIST TAKOMA PARK MONTGOMERY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Days Hours 1X□M 2□F Yrs. Director 216-40-6409 Dec 27, 1942 New York Usual Residence of Deceden with the Maryland 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at 1 XYes 2 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15209 Centergate Dr 20905 e filed within 72 hours after death vil Hygiene. other than "natural", or Items 23s USA Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 4 Senior VP Commercial Finance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked oth any niury gr other treumatic event ones. Be ဥ Benjamin Wolf Freeda Diamond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Iris Wolf/Wife 15209 Centergate Dr. Silver Spring, MD 20905 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oct 12, 2004 Judean Memorial Olney, MD 22. Name and Address of FacilityHines-Rinaldi Funeral Home 21. Signature of Funeral Service Licen 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part Enter the disease, of obmplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RESPIRATORY **Physician** WEEKS /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit ATIC that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 No detached been signed by the should be detached 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No ate has page 2 s certificate 1 ☐ Yes 2 No Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 25 No ٩ 1 Tyes Impatient 2 ER/Outpatient 3 DOA this After thi funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification; Natural 5 Pending To the nouns after death.

To the Funerel Director; Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier ⊯ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier mi (D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEINBERG, and BRYAN m. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 13 Registrar

State of Maryland / Department of Health and Mental Hygier 2004

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			1 - State Registrar					Ce	rtifica	te of L	Death	7		Reg	. No.			
			1. Decedent's Name (First, Middl	le, Last)								2. Date of	Death	D		3. Time of	Death
	Physici		Florence Lucy	z Wo	ho								Month	02	Day	Year	6:00	ам
	/Medic		4a. Facility Name (If not institution			umber)			4b. City	. Town, or	Location	of Death	OCCOL	CI		unty of Dea		
	Examin	er	9221 St. Andr	-														
			5. Social Security Number	6. Se			(In ure la	ast birthday			Par If Under		8. Date of	Rinth	<u>_</u>		George thplace (State of	
	Funeral					/. Ago	9		Months		Hours	Min.	(Month,	Day, Y		Co	ountry)	ii roraigii
	Director		241-42-4816 Usual Residence of Decedent			L							Aug.	25,	1913	3 Vir	ginia	
	and *		10a. State 10b. County	,			10c. City	Town or L	ocation								10d. Inside C	ity Limits
	sho	5																2 🔯 No
	Ne N	ect	Maryland Mont	gom	ery		Sil	er Sp		- 0- 1-				10-	01/1	()) () - () ()		
	ill or	Ē							107. 21	p Code				109	. Citizen	of What Co	ountry?	
	ath v	rai	2032 Forest Hi	11						2090					US			
	e me	ne ne	11. Marital Status		12. Was Dec Armed F	cedent E orces?	er in U.S	6. 13.	Was Dece If Yes, spe	ident of Hi scify Cuba	ispanic Or n, Mexica	rigin? (Sp ın, Puerto	ecify Yes or Rican, etc.)	No-		Race - Ame Black, Whit	ncan Indian, e, etc.	
9	within 72 hours after deeth with the Maryland ane. than "neturel", or Items 23a or 28e-f show ha Madical Ezainting must be hydiffed at	Ę.	1 Never Married 2 Mar	- 1	1 ∐Yes If Yes, G	2 ⊈N iive	lo		1 ☐ Yes	2 № No	Specify	r:			So	ecify: Wh	ite	
ğ	urel',	d by	3 XWidowed 4 □ Divorced	d	Year or I	Dates:										,		
2	72 h netu	Completed	15. Deceder (Specify only higher	nt's Edu	ication <i>le completed</i>)		(Giv	edent's Usu s kind of w	ork done c	turina mo:	st of work	ring	16	ib. Kind	of Business	Industry	
7	ithin Ban Ban	du	Elementary/Secondary (0-12)	Ť	College	(1-4or 5	+>	life.	DO NOT I	ise retired)		_					
21	or th	Co			3_			Rec	giste	red_1	Nurse	<u> </u>			_Hea	alth_C	are	
פ	al Hy	Be	17. Father's Name (First, Middle,	Last)						į	18. Moth	ier's Nam	ө (First, Mida	ile, Ma	iden Sui	mame)		
<u> </u>	Aent Aent rked tice	10	Rufus B. Wray	y							Ве	rtha	L. Ho	ope	r			
Maryland 21215-0036	sho k		19a. Informant's Name/Relations	ship (T)	rpe, Print)			19b. Mail	ing Addres	s (Street a	and Numb	er or Run	al Route Nur	nber, C	City or To	own, State, 2	Zip Code)	
Σ	alth a		Judith Lindsay	7/ E	aughte	٦r		922	St.	Andr	-W-	Ela	ce, Co	710	To I	Cark	MD 207	ire
ค์	F Heil Heil Heil Heil Markett		20a. Method of Disposition				20b. PI	ace of Disp	osition /Na	me of	-1		Date	20	c. Locat	ion - City or	Town, State	
2	age : do		1 ⊠Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (5			State		tional				20	ber 13	1.1	110	Charac	b 17-1 and	wind a
altimore,	artme orten injur		21. Signature of Funeral Service					Pag	2. Name.a	nd Addres	s of Facil						h, Vir	inia
Ba	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel; or Items 23a or 28e-f show any injury or other treumatic event, the Mudical Examinating Item Audities at any injury or other treumatic event, the Mudical Examinating Item Audities at ODEs.		Xxlat-1	1	(-)1.	`		F:	canci:	s J.	Coll	ins	Funera	1 H	ome	Inc.	, Md 20	1001
	-		23a. Part1. Enter the lise se, o shock, or heart failure. List	r comp	lical ons that	caused	the death	Do not er	ter the mo	de of dvin	n such as	DIVU s cardiac	or respirators	TTV	er s	prinq	Approximat	
				t only o	n cause on	each lin	θ.	. 20 1.01 0.		do or dy ar	9, 00011 00	5 04. 0.40	o, 100p.na.o.,	41,00	-1		Interval Bet Onset and	ween
	Physician :		Immediate Cause (Final disease or condition resulting in death)	_	a. From	icho	genie	Car	cino	na .							3 Mont	hs
	/Medical Examiner		resulting in death)				consequ											
	Examine	L	Sequentially list conditions,		b	,												
	D #	ine	if any, leading to immediate cause. Enter Underlying	Į	Due to	oras a	a consequ	ence of):										
	acute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	1	c													
Ö,	sian surial		rooditing in dodn't, care		Due to	(or as a	a consequ	ence oi):										
68760	certificate be executed Iding physician and ise as the burial-transit	/Medical		0	d													
9	ing p	Mec	IF FEMALE:	T														
O	attend for us		23b. Was decedent pregnant	- - 3	23c. If yes, or 1 □Live		of pregna≀ 2 □ Fetal		□Ectopic p	regnancy					23d.	Date of del Month		Year
m	000	Sici	in the past 12 months? 1 ☐ Yes 2 ☐ No		4∏Preg 9∏Unki		time of de		Other (s					-	1	MONTH	Day	i dai
0.0	The law requires that the de. Ite has been signed by the a bage 2 should be detached f	Physicial	9 🗆 Unknown												1			
	an the grand de de	by	Part II. Other significant conditi	ions co	ntributing to	death bu	ıt not resu	Iting in the	underlying	cause give	en in Part	I.	23e. Di	d tobac	cco use	contribute to	the cause of c	leath?
2	w require been sig should b	ed											1[Yes	2X □ N	lo 3∏Pr	obably 4 □l	Jnknown
ပ္ပ	s be	oiet											24a. W		2	4b. Were au	topsy findings completion of c	available
æ	he las e has	Completed											pe	topsy rforme	d?	death?		ause of
Vital Records,		O O	25. Was case referred to medica	al							26 Diag	o of Doot	1 Ves		Į NO	I 🗆 Yes	2 No	
5	Bicie	o B	examiner?		Hospital: 1	l Innetie	O [-D/O	-1 27 0	OA Othe	200		me 5 Re		0.17	104 (0	" Dana	hter'
ō	Phy r this ral d	-	27. Manner of Death	-	28a. Date			28b. Time			4 🗀 14		28d. Describ				0	dence
E C	Attending Physicien: or death. ector: After this certific. by the funeral director.	tion	1 X Natural 5 ☐ Pendi	ing tigation	(Mo.	nth, Day	Year)	Injury	M	28c. Injury Work	k? Yes 2.⊑				. ,		T(C)) I	acrice
S	deat deat tor:	ca	3 Suicide 6 Could	not be	28a Plac	e of Inju	inv - At ho	me, farm, s					28f Location	/Stree	at and N	lumber or Ri	ıral Route Num	her
Division of	F F F	Certification:	4 Homicide determ	ninea	build	ding, etc	. (Specify)	.,	,,			City or 1	Town, S	State)			,
_	Hospital or A 24 hours after Funerel Direc stely filled in by		29a. Certifier 1⊠ Certifyi	na Phy	sician: To th	a hest r	of my know	vladoe dea	th occurred	at the tim	ne date a	nd place	and due to th	20 02119	so(s) and	d manner as	etatod	
	24 hos Fun etely	Medical			iner: On the		examinat										to the cause(s	.)
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Me	29b. Signature and title of certific	er					29	c. License	number			29d	. Date si	igned (Mont	h, Day, Year)	
	->-0				RA	1				D13	339			(Octo	ber 1	1, 2004	
	5	- 5	30, Name and address of person	who o	ompleted car	use of de	eath (Item	23a) (Type	. Print)									
			Tsunie Chanch							Dri	ve. 1	Berwi	n Heid	ηh+«	s. M	ת 20 7	10	
	Sta	tė	31. Date filed (Month, Day, Year)	32.		ar's Signat		-			11/		-J. I. C.	, 11	201		
	Registi		OCT 13	200	4 5	mer	مم	19	100	uls	/							

State of Maryland / Department of Health and Mental Hygien 2004 34208 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** ам Lambert Francis Yore 1:05 October 11, 2004 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number)
Specialty Hospital 4b. City, Town, or Location of Death Examiner Nursing Home Cheverly
If Under 1 Year | tf Under 24 Hrs. Gladys Noon Spellman Prince George's 8. Date of Birth (Month, Day, Year) Jan. 31, 1921 5. Sociat Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 € M 2 □ F 83 Illinois Yrs Director 321-66-3292 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State Hygiene. sther then "natural", or Itams 23e or 28s-f enow ent. Its Medical Examinar must be notified at 1 Yes 2 No Directo DC n/a Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 1600 Webster Street, NE 20017 Funeral deeth 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) 5+ Priest Religious 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) es 1 and 2 should be fill of Health and Mental Hillem 27 le marked ott prother traumatic even Be John Ignatius Yore Anna Cecilia Berg P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) William C. Wert, O. Carm/Prior 1600 Webster Street, NE, Washington, DC 20017 20b. Place of Disposition (Name of October 11, 20c. Location - City or Town, State 20a. Method of Disposition metropolitan permit. Pages
Department of I
Important: If It
any injury or o 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2004 Alexandria, Virginia Crematory 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, 21. Signatur of Fur eral Service MD 20901 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) c Carpiounecular Difeete Physician HATEMOSCIEN Years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 90 Failure 3 Probably 4 Dunknown 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? Cardo respiration arest 24a. Was an autopsy performed page 2 ☑ No certificate ventilation 1 dependence 2 No 1 Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Yes 2 ☐ No 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 ENatural 5 Pending 1 ☐ Yes 2 ☐ No Director: A 2 Accident investigation 6 Could not be determined 3 Suicide Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 24 within 24 29b. Signature and title of certifier 29c. License number October 11 2004 we u 0185 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Queensbury Rd Hyatt ville MD 20781 DE Vorte MS AU (

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

OCT

12

2004

32. Registrar's Signature

			State of Maryland / Department	artment of Health and Me rtificate of Death	ntal Hygiene	2004 34209
	0		Decedent's Name (First, Middle, Last)	2	. Date of Death	3. Time of Death
	Physicia		Arthur Franklin Young		Oct 12, 20	004 Year 7:31 P M
	/Medic Examin		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		. County of Death
			Southern Maryland Hospital	Clinton	I	Prince George's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min.	Date of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)
М	Director		132 16 4114 X ^{™ 2□F} 79 Yrs.	Monard Suyo House	Sept 26, 1	1925 New York
	and	}	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Li	ocation		10d. Inside City Limits
	Aaryli f sho	ō	Maryland Prince George's Temple Hi			1 ☐ Yes 2 ☐ No
	28a-	Director	10e. Street and Number	10f. Zip Code	10a, Cit	izen of What Country?
	with 3a or		5911 John Adams Drive	20748		ited States
	death	Funeral		Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Ri		14. Race - American Indian,
ယ	or Ital	교	1 ☐ Never Married 2 ☐ Married MCYYes 2 ☐ No TATATT		can, etc.)	Black, White, etc.
8	rali, c	by	3XXWidowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 💢 Mgo Specify:		Specify: White
21215-0036	within 72 hours after death with the Maryland ene. Than "natural" or Itams 23a or 28a-f show the Medical Examinat must be notified at	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working	16b. K	ind of Business/Industry
2	nithin ne han	ďω	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		_
2	lled v tygie her t	ပိ	12 4 St. 17. Father's Name (First, Middle, Last)	atistician 18. Mother's Name (ensus Bureau
anc	2 should be filed within 72 hours after death with the Marylan n and Mantal Hygiene. I is marked other than "natural", or Itams 23a or 28a-f show raumatic evant, the Modical Examinar must be notified at	Be	Arthur Raymond Young		inor Becke	
Ž	thould Mark mark matic	٦	· · · · · · · · · · · · · · · · · · ·	ng Address (Street and Number or Rural F		
Maryland	nd 2 s Ith an 27 Is trau		AT V (C)	Axton Street., Spr		
ē,	ges 1 and 2 should n of Health and Men i if itam 27 is marke or other traumatic		20a Method of Disposition 20b. Place of Dispo	osition (Name of Dat		ocation - City or Town, State
OL.	ages ant of nt: If I		1 □ Burial XIX Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) Lee Cremation	matory or other place) atory Oct 15, 2004	Cli	nton, Maryland
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If Itam 27 Is any injury or other tra once.			2. Name and Address of Facility Lee	0-1	
ä	Depar Impo any ir once			Alexandria Ferry Roa		
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.			Approximate Interval Between
N.	Physician ·		Immediate Cause (Final disease or condition	1.00		Onset and Death
	/Medical-		resulting in death) a. Due to (or as a consequence of):	ine		0
	Examiner		Sequentially list conditions b. Athere & Charos	15		5 715
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Eine Underlying Cause (Disease or injury that partial quests.			
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Harbura Due to (or as a consequence of):			54ns
8760,	the death certificate be executed y the attending physician and croed for use as the burial-transit	E	Due to (or as a consequence or).			
87	physicate sthe	dical	d			
9 X	eath certific attending p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
Box	atter I for u	Physician/Me	in the past 12 months?	□Ectopic pregnancy □ Other (specify)		Month Day Year
0	that the de ed by the detached	ysi	1 Yes 2 No 9 Unknown			
σ,		by PI	Part II. Dther significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobacco u	use contribute to the cause of death?
ğ	w requires been sign should be				1 ☐ Yes 2	□ No 3 □ Probably 4 □Unknown
000	law re	plet			24a. Was an	24b. Were autopsy findings available prior to completion of cause of
Vital Records,	rhe age	Completed			autopsy performed? 1 ☐ Yes 2 🔊 No	death?
ita	certifical	Be C	25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
of V	S S	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	nt 3 DOA Cther: 4 Nursing Home	5 Residence	6 □Other (Specify)
0	ng P	on:	27. Manner of Death 1 ➡Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	d. Describe how injur	ry occurred
Sio	Attanding r death. ector: After by the fune	catl	2 Accident investigation	M 1 Yes 2 No	() - () ()	
Division	for At after of Direction by	Certification:	4 Homicide 3 Suicide 4 Homicide 4 Homicide 4 See Place of Injury · At home, farm, st building, etc. (Specify)	reet, factory, office 28	City or Town, State	nd Number or Rural Route Number,)
	Hospital		29a. Certifier 1 Certifying Physicien: To the best of my knowledge, deat	th occurred at the time, date and place, an	d due to the cause(s)	and manner as stated
	To tha Hospital or Attanding Phwithin 24 hours after death. To tha Funaral Director: After th completely filled in by the funeral	edical	(Check only one) 2 Medical Exeminer: On the basis of examination and/or in and manner stated.	ivestigation, in my opinion, death occurred	at the time, date and	d place, and due to the cause(s)
	To tha within 2. To tha complet	Me	29b. Signature and title of certifier	29c. License number	29d. Dat	te signed (Month, Day, Year)
			brend Cleven mo	D-00/8013	161	13/04
(30. Name and address of person who completed cause of death (Item 23a) (Type.	Print)	_	
1	BIDE		7700 OLD Brosch AVE CL	1222, MD 20731		
	Sta		30. Name and address of person who completed cause of death (Item 23a) (Type, 770 0 0 0 Blanch AVC CC 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature 0CT 1 4 2004	Contract of		
	Registr	ar	OCT 1 4 2004 Alexen A A			

	an	1. Decedent's Name (First, Middle, La			artment of Healt 28a-f per me rtificate of Dea	2. Date of I	Death	3. Time of Death
Physici /Medi Examir	cal	DAVID M ZUPKO 4a. Facility Name (If not institution, given the SO49 GARRET AVE	re street and number)		4b. City, Town, or Locat BELTSVII	ion of Death	4c. County of De	
Funeral Director				rs. last birthday) 7 Yrs.	If Under 1 Year If Un Months Days Hou	der 24 Hrs. 8. Date of E rs Min. (Month, May 8)	Day, Year)	Birthplace (State or Foreig Country) ryland
e Maryland ta-f show tiffed ut	ctor	10a. State 10b. County Maryland Charles		City, Town or Lo	ocation			10d. Inside City Limit:
h with the M 23a or 28a-f	al Director	10e. Street and Number 9 Temby Court			10f. Zip Code 20602		10g. Citizen of What USA	Country?
be filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Exacitival manuele in clifted at	by Funeral	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of Hispanic If Yes, specify Cuban, Mes 1 ☐ Yes 2 X No Spe		14. Race - Ar Black, W Specify: W	
d 2 should be filed within 72 hours alt th and Mental Hygiene. 77 is marked other than "natural", or traumatic event, I're Medical Exami	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	16a. Dece (Give life. Welde	dent's Usual Occupation kind of work done during DO NOT use retired)	most of working	16b. Kind of Busines	
2 should be filed and Mental Hygie Is marked other sumatic event,	To Be Co	17. Father's Name (First, Middle, Las Michael P. Zupko	ν			other's Name (First, Midd 1yn M. Gosho	_	
		19a. Informant's Name/Relationship Michael P. Zupko		1	ng Address <i>(Street and Nu</i> emby Court W			e, Zip Code)
Pages 1 arment of Healunt: If item inty or other	١,	20a. Method of Disposition 1X Barial 2 ☐ Cremation 3 [4 ☐ Ponation 5 ☐ Other (Speci	Removal from State	b. Place of Dispo cemetery, cre- inity Me	osition (Name of matory or other place) emorial Gard	ens 10–23–04	20c. Location - City Waldorf	
permit. Pages 1 av Department of Hea Important: If item any injury or other QDC9.		21. Signature of uneral service Lice	**	2:	2. Name and Address of F 433 White Pl	acility Eberwein	Funeral Se	rvices
/Medical Examiner lcian and pnrial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Indention. Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a condition of the cond	sequence of):				
S & 0	cal		_ d.					
S & 0	an/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time 9 Unknown	etal death 3	Ectopic pregnancy Other (specify)		23d. Date of a	delivery Day Year
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Co.

	•	For Stata Registrar	State of Maryland / Dep	ertificate of Death	vientai Hygiei Reg.	E 0 0 7	34211
Physicia	an	Decedent's Name (First, Middle, La	st)	0 /	2. Date of Death Month	Day Year	3. Time of Death
/Medic Examin	al .	4a. Facility Name (If not institution, giv	e street and number)	4b. City, Tglwn, or Location of Death	00.40000	4c. County of Death	
LAGIIII			Kins Hospital	SACTIMORE (1) If Under 1 Year If Under 24 Hrs.			
Funeral Director		5. Social Security Number 214.30.5401 Usual Residence of Decedent	7. Age (In yrs. las) birthday 13 Yrs.	/) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		731 9. Birth	nplace (State or Foreign INTY LAND
Maryland I-f show	tor	10a. State 10b. County	10c. City Town or I	ocation IMORE			10d. Inside Offy Limits 1
th with the 23a or 28a at the noti	Funeral Director	10e. Street and Number BAK	CLAY STREET	10f. Zip Code 21218	10g.	Citizen of What Co.	untry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Departments: I filed 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. It would all Exam nor must be notified all once.	by	11. Marital Status 1 Never Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces 1 Yes 2 No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 17 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White Specify: BL	
thin 72 ho e. an 'natur Medical	Completed	15. Decedent's E. (Specify only highest gra	ade completed) (Giv	edent's Usual Occupation re kind of work done during most of wor DO NOT use retired)	rking	. Kind of Business/l	
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od 2 sho lih and 17 is mu traum		19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ling Address (Street and Number or Ru	A	ty or Town, State, Z RE, ND 2	
ges 1 ar 1 of Hear 1f itam 5		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	20b. Place of Disp	position (Name of ematory or other place)	Date 20c	. Location - City or 1	Town, State
permit. Pages Department of Important: If it any injury or o		*4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lices	MRBUTUS	CEMETERY 10.3	30.04 A	ROUTUS, A	NAKY LAND WEKAL HOME
permit. Depart Import any inj		1) augus	yrun !	4905 YORK ROAM	BAUTIN	PORE, MAK	YLAND 21212
*		23a. Part1. Enter the disease, arcom shock, or heart failure. List only Immediate Cause (Final		nter the mode of dying, such as cardiac			Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a Cardiogcnic . Due to (or as a consequence of):	Shock			8 hours
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G.			completed cause of death (Item 23a) (Type			25/200	/
10	7.0 31	Jeffrey Zimme 31. Date filed (Morth, Day, Year)	2004 January Signature	in 1,600 North Wolf	C Street, B:	Itmore, M.	D 21287
Sta Registr		OCT 28	2004 Janera	& sporks			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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### Specific Name (if not institution, upon arrows and number) ### Specific Name (if not institution) ### Specific Name (if	sician	1. Decedent's Name (First, Middle						2. Date of De. Month	ath Day	Year	3. Time of Dea
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27. Vanner of Death 1 Natural 2 Naccident 3 Suicide 4 Homicide 28a. Date of Injury 6 Could not be determined 28b. Place of Injury - At home, farm, street, factory, office 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 28c. Injury at Work? 1 Yes 2 No 28b. Improf 8:00jury 6 Subject fell and hit head 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 3 Suicide 4 Homicide 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 3 Suicide 4 Homicide 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 3 Suicide 4 Homicide 28c. Location (Street and Number or Rural Route Number, City or Town, State Holiday Inn, Rm. 2 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	amo	examiner?				Ott	ner			-	
1 Natural 2	gmo		1 1 1			III 3 DOA	4 Nursing F				Motel
29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year)	To Be Comp			4-04 ^{Year)}	3:00 jury	M 1	rk?				head
29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year)	To Be Comp		ingtion C		ome, farm, st		Λ	28f. Location (Street and Nun	nber or Rura	I Route Number.
29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 28c. License number 29d. Date signed (Month, Day, Year)	To Be Comp		found	of Injury - At ho	VI		4	rederic	^{wi, Siaie} /Ho] k Coun1	tiday ty. Ma	ınn,Km.Z rvland
2004	To Be Comp		found finot be mined 28e. Place buildi	ing, etc. (Specif)	-	om					
2 2 2004	To Be Comp	27. Manner of Death 1 Natural 5 Pend 2 X Accident inves 3 Suicide 6 Coulc 4 Homicide deten	found not be mined not be build 28e. Place build found found ing Physician: To the	ing, etc. (Specify d in mot e best of my kno	tel ro	th occurred at the ti	me, date and place	, and due to the	cause(s) and n		tated.
7 hadre M. M. gras OCME October 25 2004	To Be Comp	27. Manner of Death 1 Natural 5 Pend 2 X Accident inves 3 Suicide 6 Coulc 4 Homicide deten 29a. Certifier 1 Certify (Check only one) Medica	Ind be nined 28e. Place build found found ing Physician: To the I Exeminer: On the band man	ing, etc. (Specify d in mot be best of my knowasis of examination	tel ro	th occurred at the ti	me, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and n date and place	e, and due to	tated. the cause(s)
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			For State Registrar	State of Maryland	Department of Health and Certificate of Death	Mental Hygier	211111 31.212		
	Physici		1. Decedent's Name (First, Middle	BridgeforTh		2. Date of Death Month,	Day 72 Year 2004 0930 M		
	/Medic Examin		4a. Facility Name (If not institution	, give street and number)	4b. City, Town, or Location of Deal	10-1	4c. County of Death		
	Funeral	^	5. Social Security Number	6. Sex 7. Age (In yrs. last	Months Days Hours Min		9. Birthplace (State or Foreign		
	Director	d	Usual Residence of Decedent	07	Yrs.	8/1/20	Virginia		
	e Maryla a-f shov	ctor	10a. State 10b. County	Ba	own or Location		1		
	3a or 28	i Director	10e. Street and Number	O Pun Drive	10f. Zip Code 21214	10g. (Citizen of What Country?		
10	Iter deatl	Funerai	11. Marital Status 1 ☐ Never Married 2 Marri	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.		
5-0036	72 hours after death with the Maryland natural; or Items 23e or 28e-f show lical Examiner must be notified at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ▼ No Specify: 6a. Decedent's Usual Occupation	16h	Specify: Black Kind of Business/Industry		
21	within 72 ene. then "na he Medic	Completed	(Specify only highes		(Give kind of work done during most of wo	rking	IC D - LOFF Co		
nd 2	be filed stat Hygi ed other event, I	Be Co	17. Father's Name (First, Middle,	Last)	18. Mother's Na	me (First, Middle, Maide			
ary		2	JOHN C Bri 19a. Informant's Name/Relations	alge to LYL	9b. Mailing Address (Street and Number or Ri	A MOrd ural Route Number City	or Town, State, Zip Code 2121 4		
e, M	1 and 3 Health 8m 27 ther tr	è	20a. Method of Disposition	20b. Place	5015 Herring R	Date 1 20c.	BOHOMD ocation - City or Town, State		
	Page nent o int: If		Burial 2 Cremation 4 Donation 5 Other (S)	pecify) Bal	to Mahoval (eneter)	129/04 BO	Himore, MD		
Bal	permit. Departn Importe eny inju		21. Signatu of Funeral Service	-t-Mo1363	4909 Une Klo	of Baldo	M) 21212		
	-nysician		Immediate Cause (Final	complications that caused the death. Donly one cause on each line.		or respiratory arrest,	Approximate Interval Between Onset and Death		
	/Medical Examiner		disease or condition resulting in death)	a					
1		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. In compact to pensal out to (cras a consequence of): out to (cras a consequence of): out to (cras a consequence of): out to (cras a consequence of):					
0,0	be execufed ician and burial-transit	i Examiner	that initiated events resulting in death) Last	c. /\ /c / C Due to (or as a consequence		re Visor	oder		
68760	tificate be ng physici as the bu	fedical		d					
Вох	death certifica a attending ph d for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death	ath 3 ☐ Ectopic pregnancy		23d. Date of delivery Month Day Year		
P.0	e law requires that the c has been signed by the je 2 should be detacher		9 🗆 Unknown	9☐ Unknown ns contributing to death but not resulting	g in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?		
ords,		Completed by				1 ☐ Yes			
Vital Records,						24a. Was an autopsy performed? 1 ☐ Yes 2 💆 N	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No		
Vital	sicien: Th certificate irector, pag	Be	25. Was case referred to medical examiner?	Hospital:	Oth	ath (Check only one)			
n of	ding Phys h. After this funeral di	on: To	1 ☐ Yes 2 No 27. Manner of Death 1 Natural 5 ☐ Pendin	28a. Date of Injury (Month, Day Year) 28b	D. Time of Injury 28c. Injury at Work?	Injury at Work?			
Division	r Attendi er death. rector: A by the fu	Certification:	2 Accident investig 3 Suicide 6 Could r 4 Homicide determ	not be	M 1 ☐ Yes 2 ☐ No farm, street, factory, office	28f. Location (Street a	and Number or Rural Route Number,		
Ω	To the Hospitel or Attentwithin 24 hours after death To the Funerel Director: completely filled in by the		29a. Certifier (Certifyin	g Physician: To the best of my knowled	ige, death occurred at the time, date and place	, and due to the cause(s) and manner as stated.		
	o the Ho //ithin 24 o the Fu ompletel	Medical	(Check only 2 ☐ Medical (one) 29b. Signature and title of certifier	and manner stated.	and/or investigation, in my opinion, death occu		ate signed (Month, Day, Year)		
	F > F 0		Butt	S. Fox 7.	AU4176435F		tober 26th 2004		
	10		13 STrethan		mills, mp 21117		,		
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature OCT 2 8 2004 Server & Logs (L)						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygie 20 0 4 34214 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Year **Physician** 9:30pm Mary Pauline Brzuchalski October 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BAUMOVE SAINT Agnes HEALTHCARE N/A If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖎 F 217 26 6220 Yrs. Director March 28,1929 Mary1and 75 Usual Residence of Decedent 10b. County 10c, City, Town or Location 10a. State 10d. Inside City Limits 28a-f show other traumatic event, the Madical Examiner must be notified at 1 XYes 2 □ No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 3845 Brooklyn Avenue 21225 U.S. Items 23e Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) e filed within 72 hours after all Hygiene. I Hygiene. 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White ۵ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10th Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fi and Mental H Is marked Jacob Buckey Madeline Norton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health an Alfred Brzuchalski / Husband 3845 Brooklyn Avenue Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Importent: If itel
any injury or ott 1 XBurial 2 Cremation 3 Removal from State Holy Cross Cemetery 10/23/2004 Baltimore, Maryland * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 or coordinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the disease shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Urospasi りゅうしょ disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine ed by the attending physician and detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): ian/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) Physici 9 Unknows Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has Bladder lance 1 Yes 2 No 2 No 1 Yes 25. Was case referred to medical filled in by the funeral director 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deat ate of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Hospital or Attending Natural 5 Pending investigation 1 Yes 2 No 2 Accident Director 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the I within 2 29b. Signature and title of certified Menting Thysician mpleted cause of death (Item 23a) (Type, Print) 30. Name and address of person wh 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 2 8 2004 Registrar

RZUCHALSKI, MAR

			For State	State of Maryland /			ental Hygie	ո9 Ո Ո և	34215
			Registrar 1. Decedent's Name (First, Middle, Last)		Certificate of		Reg 2. Date of Death	No.	3. Time of Death
	Physicia		BURONT	CLATTERBU	a V		October -	Day Year Zu Zoou	9:06 AM
	/Medic Examin		4a. Facility Name (If not institution, give s			r Location of Death	CIOLO	4c. County of Death	1
			UNION MEMORIA	7. Age (In yrs. last		If Under 24 Hrs.	RE	N	14
	Funeral Director		5. Social Security Number 6. Sex	M 20 F 7. Age (117 y/s. 735)	Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day, Y MA V 2 7	ear) Co	nplace (State or Foreign untry) ARVLAND
	pu .		Usual Residence of Decedent 10a. State 10b. County	10c City To	own or Location		/ /		10d. Inside City Limits
	Maryla f sho	tor		A	BA	LTIMOR	EPIT	-1/	1 X Yes 2 No
	th the or 28e or 28e	Directo	10e. Street and Number		10f. Zip Code	LIVION		citizen of What Co	untry?
	ath wi	ral	28/1 HUNTIN			1211		USA	7.
_	fter de r item	Funeral	11. Marital Status 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	13. Was Decedent of H If Yes, specify Cuba		city Yes or No- tican, etc.)	14. Race - Amer Black, White	
Š	72 hours after death with the Maryland 'natural', or items 23e or 28e-f show dical Examiner must be notified at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 € No	Specify:		Specify: B	LACK
ה	n 72 h	Completed	15. Decedent's Educ (Specify only highest grade	ation 16 completed)	6a. Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired	during most of workin	g 16	b. Kind of Business/I	ndustry
7 7	filed within Hygiene. other than "	omo	Elementary/Secondary (0-12)	College (1-4or 5+)	HEALTH	EDUCAT	OR S	ELF-EN	MPLOVED
2	be filed with ital Hygiene id other than event, It e h	Be	17. Father's Name (First, Middle, Last)	0		18. Mother's Name		•	7
2	d Meni marke matic	ဥ	19a, Informant's Name/Relationship (Type	DART DART	EE 9b. Mailing Address (Street	KARE	N C		BUCK
2	wit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artment of Heatth and Mental Hygiene. ortent: If item 27 is marked other than "natural", or items 23e or 28e-f show njury or other treumatic event, it a Madical Examiner must be notified at 9.		TAMES / AVNE	(50N)	628 N. F.	TAWST, SUI	AF.	0	21201
e,	permit. Pages 1 and Department of Health Importent: If item 27 any njury or other tr once.	L A	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	20b. Place	of Disposition (Name of tery, crematory or other place	/ Da	ate 20	c. Location - City or 1	
allillo	permit. Pages Department of I Importent: If it any njury or o		` 4 ☐ Donation S ☐ Other (Specify)	METI	The second secon	2y 11-0	1-04 X	BALTIMOR	E, MARYLAND
Ö	permit. Departn Importe any nju		21. Signature of Funeral Service License	11.12 Pellen	22. Name and Addre	HIT		JK. FUNE BALTO, I	RAL HOME
	THE		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused the death. D	to not enter the mode of dying	-	,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	AIDS					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence	ce of):				2.53.
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	ce of):				St Dud?
	cuted	Examine	cause. Enter Under vin Cause (Disease or injury that initiated events c.						
0070	cate be executed physician and the burial-transit	al Ex	resulting in death) Last	Due to (or as a consequence	ce of):				
000	ificate g phys	edical	d						-
200	The law requires that the death certific ate has been signed by the attending p bage 2 should be detached for use as	hysician/Me	23b. was decedent pregnant	ic. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea	ath 3 Ectopic pregnancy			23d. Date of deliv	,
	the at the at	yslcl	in the past 12 m <i>o</i> nths? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of death 9☐Unknown				Month	Day Year
Ļ	that the	۵.	Part II. Other significant conditions con	ributing to death but not resulting	g in the underlying cause give	en in Part I.	23e. Did tobac	co use contribute to	the cause of death?
oras,	w requires been sign should be	ed by					1 ☐ Yes	2 □ N 3 □ Pro	bably 4 Unknown
ני	law re nas be e 2 sho	Completed					24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
ומו		e Cor	OF Manager of a madical				performed		21110
>	ysicie is certi directo	0 0	25. Was case referred to medical examiner? 1 Yes 2 100	ospital: 1 Inpatient 2 ER/	Outpatient 3 DOA	26. Place of Death er: 4 ☐ Nursing Hom		e 6 □Other (Spec	ifv)
	ng Ph ifter th	on; T	27. Manner of Death 1 ☐ Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b	o. Time of 28c. Injury Work	y at 28	8d. Describe how		<i>,,</i>
מ	death.	ertification;	2 Accident investigation 3 Suicide 6 Could not be	Yes 2 □ No	28f. Location (Street and Number or Rural Route Number,				
5	al or A s after of in by	Sertif	286. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 287. Street and Number or Rural Ro						
	To the Hospital or Attanding Physicien: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director, to	edical C	(Check only 2 Medical Examin	cian: To the best of my knowled er: On the basis of examination	dge, death occurred at the tin	ne, date and place, ar	nd due to the caus	e(s) and manner as and place. and due to	stated.
	o the inthin 2 o the lomplet	Med	29b. Signature and title of certifier	and manner stated.	29c. License			Date signed (Month,	· · · · · · · · · · · · · · · · · · ·
	- s + ŏ		Ammen The	il	A	T243899		-	
	m		30. Name and address of person who con	ngleted cause of death (Item 23a	a) (Type, Print)	0.	R	NANC!	a, 7004 Md 21214
	Sta	te.	31. Date filed (Month, Day, Year)	32. Registrar's Signature	university	Tarkally	1 Dil	HMORP, 1	Ma 21214
	Registr		OCT 2 8 2004	Server 19	spoils	/			

		State Registrar 1. Decedent's Name (First, Middle, La.	it)	Ce	rtificate of	Death	2. Date of D	aath	2004	342 3. Time of De		
sicia: edica		Dorothy Hoppe Ch	enay				Octob	er 2	2004	1:05		
mine		4a. Facility Name (If not institution, given Brighton Gardens	4b. City, Town, Rockvi	or Location of Deat	h	4c. County of Death Montgomery						
al		5. Social Security Number 6. S		s. last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of B	mth.	0.8%	ethniana /Ctata as F		
		579-12-5567 Usual Residence of Decedent	□M 281F 95	Yrs.	Months Days	Hours Min.	Aug. 2	7, Tear	909 Wasi	hington,		
	-	10a. State 10b. County	10c. C	City, Town or Lo	ocation					10d. Inside City t		
	cto	Maryland Montgome	ry P	oolesvi						1 🗆 Yes 2		
Funeral Directo	בַּב	10e. Street and Number 17228 Spates Hill Road			10f. Zip Code 208	37		_	itizen of What Co ted Stat	-		
	nera	11. Marital Status 12. Was Decedent Armed Forces'		U.S. 13.	Was Decedent of	Was Decedent of Hispanic Origin? (Specify Yelf Yes, specify Cuban, Mexican, Puerto Rican, 1 ☐ Yes 2₺ No Specify:		0-	14. Race - Ame Black, Whi			
1	by Fu	1 ☐ Never Married 2 ☐ Married 31 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 21 No If Yes, Give	1 ☐ Yes 21 No					Specify: White			
		15. Decedent's E	ducation	16a. Dece	dent's Usual Occu	pation	rking	16b. i	W I Kind of Business			
Completed	mple-	(Specify only highest gra	College (1-4or 5+)			during most of wo	rking					
	e Co	17. Father's Name (First, Middle, Last)			Accountar	18. Mother's Nai	me (First, Middle			<u> </u>		
To Be	m	James O. Hoppe				Agnes 1	Morgan		ccounting den Sumame) ity or Town, State, Zip Code) 20852			
		19a. Informant's Name/Relationship (. ,		Zip Code)		
	-	Patricia C. Baugh		Place of Dispo	osition /Name of		Date		ocation - City or	r Town, State		
		1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	Gate of	matory or other pla of Heaven	Oct			ver Spri	ing,		
8		*4 Donation 5 to Other (Specify) Entombrent Mausoleum 2004 Maryland 21. Signature of Funeral Service Doensee M00689 M00689 M00689 Mausoleum 2004 Maryland 22. Name and Address of Facility Robert A. Pumphrey Fune Rockville, Inc., 300 West Montonery Av Rockville, Maryland 20850-2805							uneral Ho			
) / M006	89	Rockvi	lle, Mar	vland 20	850	-2805 Ty	Approximate		
Examiner		23a. art1/Ener/ ne di ease, or com nockkir hir it fature. List only Immedi te ause (Final				ng, such as cardia	c or respiratory	illest,	3	Interval Betwee		
		disease or condition resulting in death)	Respirato Due to (or as a conse	Lure	-11							
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	mine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events (Cause Consequence of the cause) Enter Underlying Cause (Disease or injury that initiated events (Cause of Cause of										
	8	that initiated events resulting in death) Last						_				
		resulting in doubly case	The second second							1		
1	20	resoning in doubly east	d. Dementia									
1	20	IF FEMALE:	23c. If yes, outcome of preg						23d. Date of de	elivery		
•	20	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe	ital death 3[□Ectopic pregnanc	ey .			23d. Date of de Month	elivery Day Yea		
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	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3[death 5[Other (specify)	·		tobacco Yes 2	Month use contribute to			
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 0 0 14 1 - For State Registrar 34217 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month October 23, Sandra King Cooley 2004 1:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 12240 Roundwood Rd. Unit 204 Timonium Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day,) Feb. 19 1 941 Birthplace (State or Foreign Country) 1 M 2 X Days Hours Maryland Director 179-32-3731 63 Yrs. Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exarch at mast be notified at 1 ☐ Yes 2 No Director MD Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 12240 Roundwood Rd. Unit 204 21093 United States death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural', or iten any injury or other traumatic event, If a Medical Exertina. Once. Armed Forces? 1 XYes 2 No 1969-If Yes, Give Year or Dates: 1971 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White 3 ☐ Widowed 4 ☒ Divorced 1971 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Insurance Broker Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul L. Kino Marv G. Gregory 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) T. Kevin King/nephew 15416 Whitechapel Ct. Centreville, VA. 21020 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Arlington Nat. Cemetery 12/09/2004 Arlington, VA. 21. Signature of Funeral, Service Licenty 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. S. Coster 1050 York Road, Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Kym Blom A /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the 1 Yes 2 No 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, pe 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1 Tyes Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) hours after 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ical 29a. Certifier (Check only onel within 2 To the To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ND D59858 UCTOBER. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HERKINS 401 BROADURY AVE BALTIMORE MD 2123 31. Date filed (Month, Day, Year)
OCT 2 8 2004 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiens 1 - For State Registre Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Henry E. Doll Month 1:45 PM October 23, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Eldercare Gardens Halethorpe Baltimore 5 Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Jan 8, 1923 9. Birthplace (State or Foreign 1XM 2□F 218-18-1690 Director 81 Yrs Maryland Usual Residence of Decedent 10a State 10h Counts 10c. City, Town or Location 7 is marked other then "neturel", or items 23e or 28e-f show treumatic event, the Medical Exerciter must be retified at 10d. Inside City Limits Baltimore Maryland 1 ☐ Yes 2 No Director Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5108 Shelbourne Road 21227 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White ρ Specify. 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked other then Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Paper Cutter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Doll Catherine Myrtle Musqrove 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) pernit. Pages 1 and 2 Dep. itment of Health a Importent: If item 27 Is any injury or other treu QDDCs. Raymond Lins / Nephew 1239 Circle Drive, Halethorpe, Maryland 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 10/27/2004 Baltimore, Maryland ` 4 Denation 5 ☐ Other (Specify) 21. Fignature of Funeral Service Licenses 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MY OCARDIA 30 ruis disease or condition resulting in death) /Medical Due to (or as a consequent **Examiner** Sequentially list conditions, if my leading to impression cause. Enter Underlying Cause (Disease or injury Examiner that initiated events resulting in death) Last Due to (or as a consequence of) burial-Box 68760, Physiclan/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 10 in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. ፩ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? sease 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 - No of Vital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 4 □ Nursing Home 5 □ Residence 6 ₽other (Specific Society) Hospital: Other: 1 ☐ Yes 2 ☑ No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 3 🗀 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 ☐ Homicide To the Hospital within 24 hours a To the Funerel [filled 1 Certifying Physician: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifies 29d. Date signed (Month, Day, Year) 16200 IVA or person who completed cause of death (Item 23a) (Type, Print) Choice LA. CATOPSVIlle N.M , MACHIRAN 720-CMAIDEN 31. Date file 1 Porth 2 a 8 y 2004 2. Registrar's Signature State Registrar

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and *		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						10d. Inside City Lîmits
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To the Hospital or Attending Physician: within 24 hours alter death within 25 to the Funaral Director. After this certified completely filled in by the funeral director, goompletely filled in by the funeral director, it		29a. Certifier '4 Certifying	Physician: To th	e best of my kno	owledge, death	occurred at the	time, date an	nd place, a	nd due to the ca	ause(s) and m	anner as s	tated.
na Ho na Fu na Fu	edical	(Check only 2 Medical E	xaminer: On the	basis of examina nner stated.	ation and/or inv	estigation, in my	opinion, dea	ath occurre	d at the time, d	late and place	, and due to	o the cause(s)
To the To the To the Comp	M	29b. Signature and title of certifier	1				nse number			9d. Date sign		
		Muu	AT IT	- P.ICU	LUVILL	1	4618	7	0	CTOBE	R 1	7 2004
		30. Name and address of person v			n 23a) (Type,	Print)	_		//			
2	1.77	AJIT P. KURU		ms;	11125	ROCKVIL	LE PI	KE/	H108	ROCKU	ille	7, 2004 , MD 20852
Sta Registi		31. Date filed (Month, Day, Year)		Registrar's Signa	ature	lon V	,	,	/			

DHMH 17 Rev 1/2001

34221 Registra MEND ITEM #5 PER FH G837 11 Gertificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** October 0 Rose Marie Deskins 2004 4:31 A. 17 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Harford Memorial Hospital Havre De Grace Harford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 27, 1 5. Social Security Num**9789**216 34 1989 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 ☐ M 2 🔀 F Yrs. 1936 67 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h Counts Ceci1 1 ☐ Yes 2 No Maryland Rising Sun Direct 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ral', or Itams 23a or Examiner must be r 51 SunRise Drive 21911 U.S. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White ğ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 8th Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental William Youngbar Helen Jacobs ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health ar Important: If itam 27 is any injury or other trau once. Ivan Deskins Husband 51 SunRise Drive Rising Sun, Maryland 21911 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 10/19/2004 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury a consequence of): The law requires that the death certificate be executed. MSVOWS Mydins that initiated events resulting in death) Last to (or a a consequence of): attending physician a for use as the burial-t Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregpant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 N 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 81151m 24a. Was an this certificate has 1 Yes 2 No 2 ☑ No 1 Yes tha Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA After this funeral d 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending death. 2 No investigation 2 Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a a Funaral [1 [Jocertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To tha 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7.M 64 person who completed cause of death (Item 23a) (Type, Print) 30. Name and address di 1 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygie 10 0 4

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year Rose Desticids Oc 1 1:50 AM /Medical 2004 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Touse -GILCHNIST 1/0spice Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 🔀 F Director 06 205-20-1875
Usual Residence of Decedent SC the Maryland 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits itam 27 is markad othar than "natural", or itams 23a or 28a-f show othar traumatic avant, it a Modical Examinar must be notified at Director XXes 2 No NA Philadelphia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19121 2600 Glenwood Drive Apt E U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. iled within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 ♥ Widowed 4 Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12th grade na Assembly Line Worker Candy Factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be should be fi Eugene Gidreon Georgia Commander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: if itam 27 Is n any injury or othar traum 20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. Location - City or Town, State Lisa DeShields-Daughter 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Merion Cemetery 10/28/04 Bala Cynwyd, PA Signature of Fineral Service License 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Bladder Cancer Metastatic disease or condition resulting in death) Mon T45 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) P.O. the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has te certificate of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division To the Hospital or Attanding 1 Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No Diractor: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ò 4 Homicide determined within 24 hours at To tha Funaral D completely filled in 1) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Laron Willas D0061199 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Black 6601 North Charles ST ins louson M1021204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Deshields,

State of Maryland / Department of Health and Mental Hygiezen 0 L 34223 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month C **Physician** DOMOWSKI Year WILLIAM EDWARD 11,05AM 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A VABRECC BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) JAN. 5, 1923 **Funeral** 1 M 2 □ F Months Days Hours Min. 81 215-14-4106 Director Usual Residence of Decedent tiled within 72 hours after death with the Maryland show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or items 23a or 28e-f show Director MD. 1 ▼ Yes 2 No N/A BALTIMORE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 314 JOPLIN STREET 21224 U.S.A. Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Yes 2 Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Divorced Specify: WHITE Year or Dates: Completed the Madical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) 6TH College (1-4or 5+) BRICKLAYER CONSTRUCTION uth and Mental Hvo. 7 is marked othe treumetic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Importent: If item 27 Is marked any injury or other treumetic events. JOHN DOMOWSKI FRANCES FRANKOWSKT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOLORES DOMOWSKI/WIFE 314 JOPLIN ST., BALTIMORE, MARYLAND 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State HOLLY HILL CEMETERY 10/28/04 ' 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE.. BALTIMORE, MARYLAND 21224 6224 EASTERN AVE., BALTIMORE, MARYLAND 2sseen 23a. Part) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Ma /Medical Due to (or as a con) equence of): **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dile to for as a nonsequence off The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. by Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 2 100 1 ☐ Yes 1 Yes 2 100 of Vital or Attending Physicien: after death.

Director: After this certities
In by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 pursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 100 Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 019402 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VA BRECC AUJL 5. DE 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar OCT 2 8 2004

				State of Maryland						3	
			1 - For State Registrar	otato or marytaris		rtificate of l		•	Reg. N6	7094	01.001
	_0		Decedent's Name (First, Middle, La	ast)			-	2. Date of De	ath	. U U 4	S. Tiffelds Death
	Physicia /Medic			James Benjamin	Eth	eredge		Octobe	r 25	, 2004	10:36 A M
	Examin		4a. Facility Name (If not institution, gir			4b. City, Town, or	Location of Deat	h	4c.	County of Deat	h
			Suburban Hospita			Bethesd				ontgome	-
	Funeral Director		362-01-0806	Sex 7. Age (In yrs. Ia 1₩ 2□F 92	rst birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birt (Month, Da April 1	3, 19	9. Birt Cc A1a	hplace (State or Foreign untry) Dama
	and and		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation				-	10d. Inside City Limits
	Mary First	tor	Maryland Montgom	erv Bet	hesda						1 ☐ Yes 2 No
	r 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citi	zen of What Co	untry?
	23a c		7106 Bells Mill	Road		20817			Uni	ted Sta	tes
	r dea	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	13. \	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No	-	14. Race - Ame Black, White	
ဗ္	or it	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 K Yes 2 □ No If Yes, Give WWI Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:	,			
9500-5121	be filed within 72 hours after death with the Maryland to Hygiene. d other than 'natural', or items 23s or 28s-f show event, it is Madical Examiner must be motified at	ed b	15. Decedent's E		16a Decer	dent's Usual Occupa	ation			W	hite
CI.	nin 72 n n na	Completed	(Specify only highest gr	ade completed)	(Give	kind of work done of NOT use retired	during most of wor	rking	IDD. KI	nd of Business/	industry
7[7	d with giene ir tha	mo	Elementary/Secondary (0-12)	College (1-4or 5+) 5+	Moti	on Pictur	e Produc	er	Fede	eral Go	vernment
פ	e filed v	Be C	17. Father's Name (First, Middle, Las	1)			18. Mother's Nar	ne (First, Middle,	Maiden	Sumame)	
<u>a</u>	Menta Menta arked	70	John Berry Ether	edge			Maude	Belle Mo	organ	ı	
Maryland 2	and and is ma		19a. Informant's Name/Relationship	11/		ig Address (Street a					
2	and lealth m 27 har tr		Lloyd S. Ethered			Bells Mil					
Baltimore,	ges 1 t of H Hita or ot		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 [sition (Name of natory or other place	e) Octo	ber 29,		cation - City or	
	t. Par tmen tant: njury		' 4 □Donation 5 □ Other (Speci	**		Cemetery		•			Maryland
<u> </u>	permit. Pages 1 and 2 should be filed will be perment of Heath and Aental Hygienn Important; if Itam 27 is marked othar this any njury or othar traumatic evant, the once.		21. Signature of Funeral Service Lice	M0130	5 Rol 75	Name and Address bert A. Pun D7 Wisconsi	is of Facility iphrey Fun in Avenue,	eral Home/ Bethesda,	Beth Mary	esda-Chev 71and 208	y Chase, Inc. 14-3501
			23a. Part1. Inter the disease, or con shock, or heart failure. List only	nplications that ceused the death.	Do not ente	er the mode of dying	g, such as cardiad	or respiratory ar	rest,	0	Approximate Interval Between
F	Physician		Immediate Cause (Final disease or condition	a Ischemic Ca	rdiom	yopathy					Onset and Death 8 Months
	/Medical Examiner		resulting in death)	Due to (or as a conseque							10 M
	-xammer		Sequentially list conditions,	b. Coronary Ar		Disease					30 Years
Vi	nsit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Hyperlipide	,						Years
۷.(۵0,	sician and burial-transit	xar	that initiated events resulting in death) Last	c. Due to (or as a conseque						-	rears
/60,	ysiciar e buri	calE		d							
	g phy as the										
go	death certifica e attending ph d for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnand		Ectopic pregnancy			2	3d. Date of deli	very
ים כ	e dear	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of dea		Other (specify)				Month	Day Year
л Э	at the	Phy	9 Unknown								
Ś.	sician: The law requires that the death certificate certificate has been signed by the attending physrector, page 2 should be detached for use as the	by	Part II. Other significant conditions Myocardial Infar				en in Part I.		_		the cause of death?
cords,	neen (eted	11) Ocal alai IIII al	ecton, medicane	1 3 0	- Inchesta		1 4	es 210	No 3 Pro	obably 4 Unknown
d) !	has b	ompleted						24a. Was a autop	sy	prior to c	opsy findings available ompletion of cause of
	r. Ine	O						perfor	med? 2X No	death?	2 🗆 No
Vital	rnystcian: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		Othe		th (Check only or			
0	ding rnysician: h. After this certific funeral director,	. To	1 ☐ Yes 2 X No 27. Manner of Death	28a. Date of Injury 2	R/Outpatient 28b. Time of	3LI DOA	4 Nursing n	ome 5 Resid			ify)
5	th. TAfte	tlor	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	28c. Injury Work	?? /es 2 □ No		,,	000000	
noision	Attar r dea actor by the	Certification;	3 ☐ Suicide 6 ☐ Could not b	28e. Place of Injury - At hom	ne, farm, stre	eet, factory, office		28f. Location (S	treet and	Number or Ru	ral Route Number,
בֿ בֿ	s afte	Sert	4 Homicide determined	building, etc. (Specify)				City or Tow	n, State)		
4	i o the mospital or Atlanding Priving 24 hours after death. To tha Funaral Diractor: After the completely filled in by the funera	edical (29a. Certifier 1 Certifying Pl (Check only one)	hysician: To the best of my knowl miner: On the basis of examination and manner stated.	ledge, death on and/or inv	occurred at the tim restigation, in my op	e, date and place inion, death occu	, and due to the c rred at the time, d	ause(s) a late and	and manner as place, and due	stated. to the cause(s)
	o the	Me	29b. Signature and title of certifier			29c. License	number	2	9d. Date	signed (Month	, Day, Year)
,	> - 0		1 Janes	miller	7	D3557	79			er 25,	
]				19.1.2.2					2004
	N		30. Name and address of person who	completed cause of death (Item 2	23a) (Type, F					JEI 25,	2004
	30M		30. Name and address of person who Susan J. Miller, 31. Date filed (Month, Day, Year)		ip Hil	orint)					2004

DHMH 17 Rev 1/2001

				partment of Health and M	-		
	_ = _			ertificate of Death	Reg	100 L	34225
	Physici /Medio		Decedent's Name (First, Middle, Last) Judy A. Fauth		2. Date of Death Month October	Day Year 25, 2004	3. Time of Death 4:33 P M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
	Eupeval		Gilchrist Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Towson If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Baltimo	re ace (State or Foreign
н	Funeral Director		220-36-1845 1□ M 2XDF 64 Yrs.	Months Days Hours Min.	Oct. 27,	1939 Mary	y)
	p .		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or		,		
	Aaryla F show	or				100	d. Inside City Limits 1 ☐ Yes 210100
	28e-	Directo	10e. Street and Number	onium 10f. Zip Code	100	. Citizen of What Countr	
	n 72 hours after death with the Maryland "naturel", or Items 23a or 28e-f show solical Examirer must be nutified at		1 Lucan COurt Unit 302	21093		U.S.A.	
	ems (Funeral		. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Black, White, et	
36	s afte	by Fu	1	1 ☐ Yes XX No Specify:		Specify:	
2-0036	P hour		15. Decedent's Education 16a. Dec	edent's Usual Occupation	16	Whi:	
2 2 2	within 72 ene. then "nai	Completed	(Specify only highest grade completed) (Giv	e kind of work done during most of worki DO NOT use retired)	ing	s. Tara of Basinessama	istry
7		Соп	12	Secretary		U.S. Govern	ment
שב	0 = 0 >	Be	17. Father's Name (First, Middle, Last)		(First, Middle, Ma	,	
Maryland	hould d Mer marke metic	2	John M. Fauth 19a. Informant's Name/Relationship (Type, Print) 19b. Mai	Shirle ling Address (Street and Number or Rura	×	illespie	2.4.1
<u>8</u>	and 2 s ealth an n 27 is her treu		Catherine F. Berkeridge Sister 102				
ē,	- T = =	1 :	20a. Method of Disposition 20b. Place of Disp			nium, Maryla c. Location - City or Tow	n, State
altimore,	Page ment c ant: If ury or		I Li bullati 2 Li Cremation 3 Li Removal from State	Service Corp 10-27	-2004	Towson N	Maryland
gall	permit. Pages Department of I Important: If ite any injury or or once.		21. Signature of Emeral Service Licensee	22. Name and Address of Facility Ruc	k Towson	Funeral Hom	me, Inc.
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	the at	/sicl		Other (specify)		Month D	ay Year
Ţ	that the ed by detac		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to the	cause of death?
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ב	The late hap page	mo			autopsy performed 1 ☐ Yes 2 🔀	d? death?	letion of cause of
אוושווא	cien: ertific actor,	Be (25. Was case referred to medical examiner?	26. Place of Death			
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5	th. After	tlon	1 R Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	
VISION	Atter or dea octor by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s		28f. Location (Stree	t and Number or Rural R	Route Number,
5	itel or rs afte el Dir led in	Cert	4 Homicide building, etc. (Specify)		City or Town, S	itate)	
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2 to ompletely filled in by the funeral director, page 2.	edical	29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, deal 2. Medical Examiner: On the basis of examination and/or is and manner stated.	th occurred at the time, date and place, a nvestigation, in my opinion, death occurre	and due to the caused at the time, date	e(s) and manner as state and place, and due to th	ed. le cause(s)
	To th withir To th comp	×	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Da	y, Year)
			J. G. Husting Mily no	25205	00	Aober 25	2004
	20		30. Name and address of person who completed cause of death (Item 23a) (Type W. A. R. (ey G. G.M. C. 6781 N. Chur	Print) les St. Balts. Me	1 2120	>	
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature				
	Registra	ir	OCT 2 8 2004 Seture &	Sparks			

State of Maryland / Department of Health and Mental Hygien 0 0 1 34226 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October 27, 2004 FLORA THOMAN FRANZ 12:35AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St Elizabeth Nursing Home Baltimore N/A | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Park | 1900 | 9. Birthplace (State of Min. | Days | Hours | Min. | December 13, 1905 | Mary 1 and 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 XX 219-34-1240 98 Yrs. Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show Director Maryland N/A YYYes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3320 Benson Avenue 21227 USA or Items 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2ADNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes aXXNo Specify: Specify 3XXVidowed 4 ☐ Divorced 'natural', White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If itsm 27 is marked other than 'any righty or other traumatic event, Ire Me 2008. Elementary/Secondary (0-12) College (1-4or 5+) Account Clerk State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Thoman Pauline Eyth ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sr. Dorothy P Franz DTR 3020 Autumn Branch Lane Apt D Ellicott City Md 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State Baltimore National 11/3/04 □Donation 5 □ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility MITCHELL-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Aset and Death **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner physician and the burial-transit Hospitel or Attending Physiclan: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 1 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes ≥ No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide filled in within 24 hours in To the Funeral Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 52746 October 27, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yelena Lipnik MD 720 Maiden Choice LAne Suite C Baltimore, Maryland 21228 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

OCT 2 8 2004

ORIGINAL

5946		1- For Amend Item 41	State of Ma per ME,	aryland / Der G836, 1072	partment of	Health an <i>Death</i>	d Mental Hy	giene Reg. No. 2 N N		
Physici /Medio		1. Decedent's Name (First, Middle, Last) Mark Harry Gol	dstraw				2. Date of De Month			
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Funeral Director		5. Social Security Number 214-64-7576 6. Sex 152 152 152 152 152 152 152 152 152 152	M 2□F 7. Ag	e (In yrs. last birthda 51 Yrs.	/) If Under 1 Year Months Days		Hrs. 8. Date of Bin Min. (Month, Da DEC 8,	th Year) 9. E 1952 Ma	Birthplace (State or Foreign Country) ryland	
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ath with th	ral Dire	10e. Street and Number 3 Lucan Court			10f. Zip Code	21093		10g. Citizen of What US		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exeminer must be notified at angle.	by Funeral	11. Marital Status 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		. Was Decedent of If Yes, specify Cub		? (Specify Yes or No uerto Rican, etc.)	- 14. Race - Ar Black, Wi Specify:	nerican Indian, nite, etc. whi.te	
21215-0036 di within 72 hours ali gigne. gigne. i tre Madic: Exerni	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5	(Giv	edent's Usual Occu to kind of work done DO NOT use retire Salesma	during most of od)	working	16b. Kind of Busines Network	,	
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and 2 sho Balth and n 27 is m		19a. Informant's Name/Relationship (Ty). David S. Goldstra		er 103	35 Lakemoi			er, City or Town, State .lle, MD 2]		
Baltimore, permit. Pages 1 ar Department of Hea mportant: If item any injury or otha		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	1 -	position (Name of ematory or other pla Nemon:	· 1	Date /29/2004	20c. Location - City of	orTown,State sville,MD	
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10		30. Name and address of person who cor	npleted cause of de	eath (Item 23a) (Type		n Stree		ore, Maryl		
Sta Registr		31. Date filed (Month, Day, Year) OCT 2 8 2004	32. Registra	r's Signature	don		-	- -		

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OCTOBER 22, 200	within To the comple	-	29b. Signature and title of certifi		4						

State Registrar DHMH 17 Rev 1/2001

OCT 2 8 2004

Sporks

		1	For State Registrar	State of M	aryland / Depa <i>Ce</i>	artment of He	ealth and M Death	lental Hygi	e2e004	34229
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	Examin	er	la. Facility Name (If not institution Stylingore Peliolit Social Security Number	litation EX	ended Cake	4b. City, Town, or Back If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	4c. County of Dea	thplace (State or Foreign
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	ath with th	ral Dire	10e. Street and Number 1329 Medfield			10f. Zip Code	21211			USA
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	nd 2 s lith ar 27 ie r trau		19a. Informant's Name/Relations Trudy Garrison	thip (Type, Print) (Wife)		ng Address (Street a Medfield			City or Town, State, ore, MD 21	
Baltimore,	00-	8	20a. Method of Disposition 1 ☐ Burial 2X X Cremation 4 ☐ Donation 5 ☐ Other (S			osition (Name of matory or other place ort Crema	a)		20c. Location - City of Alexandria	
Balt	permit. Page Department of Important: If any injury or		21. Signatu Funeral Service	X Carper	tu 3	2. Name and Addres Jurgee-Hen 631 Falls	ss-Seitz Road Ba	Funeral	Home, Inc , MD 21211	
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Division	Attending r death. sctor: After by the fune	Certification;	27. Manner of Death 1 Natural 5 Pendi invest 3 Suicide 6 Could 4 Homicide	igation (Month, D	njury - At home, farm, s	M 1 🗆 '	k?" Yes 2 □ No		reet and Number or F	Rural Route Number,
Ö	Hospital or 24 hours afte Funerel Dire tely filled in I	edicai Cert	29a Certifier 1 X Certifyi	ing Physicien: To the besi Exeminer: On the basis and manners	t of my knowledge, dea of examination and/or	ath occurred at the time	ne, date and place pinion, death occu	, and due to the ca	ause(s) and manner a ate and place, and du	as stated. le to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certific	-	0	29c. Licenso			9d. Date signed (Mor	-
	15x1	\	30. Name and address of person	n who completed cause of	death (item 23a) (Type 900 Lach F	a, Print) Paven B.C.	vd Balt	imore.	MD 2/2	218
	· St Regist	ate trar	31. Date filed (Month, Day, Year OCT 2	8 2004 32. Regis	trar's Signature	& Span				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Date of Deeth 3. Time of Death Month **Physician** EVELYN 26 5:20 AM GREGORY 1701 2004 /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Future Care of the Chesapeake Arnold if Under 1 Year Months Days If Under 24 Hrs. Hours Min. 7. Age (In yrs. lest birthdey) 5. Sociel Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F 81 198 18 1952 Director 1923 Pennsylvania Usuel Residenca of Decedent 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits 28a-f show the Medical Examiner must be notified a 1 ☐ Yes 2X No Baltimore Directo Maryland Anne Arundel 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours efter deeth with ò Herns 23a 144 W. Edgevale Road 21225 U.S. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 12(No If Yes, Give Yeer or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: White ò Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Social Security Elementery/Secondary (0-12) College (1-4 or 5+) Key Punch Supervisor Administration 12th other 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Peges 1 and 2 should be fill ment of Health end Mentel Hant: If Item 27 is marked other Glovanni Brunetti Melia Beretta 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) pertment of Health enc portant: If item 27 is n y injury or other traun Roman Gregory / Husband 144 W. Edgevale Road Baltimore, Maryland 21225 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □XBurial 2 □ Cremetion 3 □ Removal from State Glen Haven Mem. Park 10/29/04 Glen Burnie, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 nanwour 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Physician /Medical Immediate Ceuse (Final disease or condition resulting in death) ACUTE MYCLARDIAL INFARCTION Examiner Due to (or as a consequence of): Examiner ete hes been signed by the ettending physician end page 2 should be deteched for use as the buriel-transit Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ARTERY Completed by 24b. Were autopsy findings 24a. Was an autopsy performed? available prior to completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Medical Certification: To 41 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA nours efter death.

neral Director: After this y filled in by the funeral di 28a. Date of Injury (Month, Dey Year) 28b. Time of 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 0 To the Hospital or within 24 hours eff To the Funeral Di completely filled in 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the ceuse(s) and manner as steted.
2 **Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier 29d. Date signed (Month, Dey, Year) 29b. Signature end title of certifier D57531 MD

State Registrar DHMH 16 Rev 6/95 Millersville, MD 21108

8601 Veterans

32. Registrar's Signeture

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

2004

31. Dete filed (Month, Day, Year)

OCT 28

			1 - For State Registrar	State of Maryland / D	epartment of Health and N Dertificate of Death	Mental Hygier		34231
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	dricks		2. Date of Death	Day 2004	3. Time of Death 4:05 A.M
	Examin Funeral Director		4a. Facility Name (If not institution, give s TO SEPH AICH I 5. Social Security Number 2/16-8/4-2/8/9	E HOSPICE 7. Age (In yrs. last birth	4b. City, Town, or Location of Death ALTIH (day) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	4c. County of Death N/A 9. Birthpl County AA AA AA AA AA AA AA AA AA A	ace (State or Foreign try)
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. It marked other than "natural", or Itams 23a or 28a-f show umaric evant, tre Medical Evantiner must be notified at	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County MARYLAND 10e. Street and Number OMOUNTAI 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edur (Specify only highest grade Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) LERO VO 19a. Informant's Name/Relationship (Ty,	College (1-4or 5+)	BALTIMOR 10f. Zip Code 2 13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify: Decedent's Usual Occupation Give kind of work done during most of work iffe. DO NOT use retired) 18. Mother's Nam	ecity Yes or No-Rican, etc.) 10g. 6 10g. 6 16b.	itizen of What Count USA 14. Race - America Black, White, e Specify: BL Kind of Business/Ind WCIA en Sumame)	Dd. Inside City Limits 1 Yes 2 No try? an Indian, atc. LUK
Baltimore, Ma	permit. Pages 1 and 2 Department of Health a Important: If itam 27 le any injury or other tra once.		20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	emoval from State Control Contr	MOUNTAIN GREEN (Disposition (Name of crematory or other place) CREMATORY 10-2	PAROLE BAL Date 20c.	Location - City or Too	21244 wn, State , MARYLAND L HOME
8760,	Lusaminet Lansit the buffar-Iransit the buffar-Iran	dicai Examiner	23a. Part1/Enter the disease, or complished, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):	or respiratory arkst,	() 0	Approximate Interval Between Ogset and Death
.O. Box 6	The law requires that the death certificate has been signed by the attending playage 2 should be detached for use as I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 gronths? 1 □ Yes 2 □ No 9 □ Unknown	Sc. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliver Month	y Day Year
Records, P	w requires that been signed b should be deta	by	Part II. Other significant conditions con	tributing to death but not resulting in t	he underlying cause given in Part I.	23e. Did tobacco	use contribute to the	V
al Reco		Completed				24a. Was an autopsy performed?	prior to com death?	sy findings available pletion of cause of
Division of Vital	ding Phys h. After this funeral dii	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No H 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	ospital: 1 Inpatient 2 ER/Outp 28a. Date of Injury (Month, Day Year) 28b. Tir	patient 3 DOA Other: 4 Nursing Ho	h (Check only one) me 5 Residence 28d. Describe how in		Hospite
Divi	fter fter jira n b		4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Street a City or Town, Sta	.te)	
	To the Hospital within 24 hours a To the Funeral completely filled	Medical	(Check only one) 2 Medical Examir one) 29b. Signature and title of certifier	er: On the basis of examination and/ and manner stated.	or investigation, in my opinion, death occurr	red at the time, date a	nd place, and due to Date signed (Month, D	the cause(s)
	7		30. Name and address of person who co	mpleted cause of death (Item 23a) (T) 125 /2 ype, Printy - 00 0 0	12 04 =	0/27/40	2017
	Sta Registr		31. Date filed (Month, Day, Year) OCT 2 8 2004	32/Registrar's Signature	sports	Salthis	R 101) 2	440

HENDROKS

457

			For State Registrar	State of Ma	aryianu	Cer	rtificate of	ieaith and Death	Mental Hy	gien Reg. N		342	32
	Diversity in		1. Decedent's Name (First, Middle, La	Matthew	Lee E	leckan	ian AK	Ā	2. Date of De	ath	ay Year	3. Time of	Death
	Physici /Medic			Matthew	Adria	n Fer	raro		Octobe		0, 2004	4:05	A M
	Examin	er	4a. Facility Name (If not institution, giv					r Location of Dea	th	4	c. County of Death		
			8125 Exodus Driv		- // /-	-	Gaithei	sburg		Montgomery			
	Funeral Director		303-88-3342	ex 7. Ag ⊠M 2□ F	e (In yrs. Ia: 22	Yrs.	Months Days	Hours Min		v. Yea <i>i</i>	9. Birthp County 182 Inc	lace (State o try) liana	or Foreign
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation				1	0d. Inside Ci	ity Limits
	be filed within 72 hours after death with the Maryland tial Hygiene. ad other than "natural", or items 23a or 28a-f show avent, the Medical Examination to the incitied at	ctor	Maryland Montgom	ery	Ga	ither	sburg					1 🗌 Yes	
	of 28	Funeral Director	10e. Street and Number				10f. Zip Code			10g. C	itizen of What Coun	try?	
	death v	rai	8125 Exodus Drive		E : 110	10.1	20882				ited Stat		
	item	-un	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Armed Forces? 1 X Yes 2 □		. 13. 1	Was Decedent of H f Yes, specify Cuba	an, Mexican, Pue	nto Rican, etc.)	'	14. Race - Americ Black, White,		
336	hours after tural', or ite		3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 21☑ No	Specify:			Specify: Wh	ite	
9	72 hou	Completed by	15. Decedent's E	ducation		16a. Deced	dent's Usual Occup	ation		16b. I	Kind of Business/Ind	lustry	
215	thin 7	nple	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or s	5+)	life.	kind of work done DO NOT use retired	during most of wi	orking	U:	nited Sta	tes	
2	filed wil Hygien ther th	Con	-	2.			PV2				Army		
nd	tat H	Be	17. Father's Name (First, Middle, Last,						me (First, Middle,		,		
yla	2 should be and Mental is marked of raumatic ave	2	Marshall Heckama			10h 14-35		Claire				0- 1-1	
Maryland 21215-0036	d 2 st th and 7 is n traun		19a. Informant's Name/Relationship (Stacie J. Ferraro							-	or Town, State, Zip	Code)	
	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any injury or other traumatic once.		20a. Method of Disposition	/ wile	20b, Pla	ce of Dispo	sition (Name of		Date		MD 20882 Location - City or To	wn, State	
Baltimore,			1 ☐ Burial 2 ☑ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specif		Mo	netery, crer n t g om	natory or other place ery	⁽⁸⁾ 0ct	ober 29, 004				1
Ħ	artme ortan injur		21. Signature of Funeral Service Acer	- / \	Crem	22	um. Inc. . Name and Addre	ss of FacilityRo	bert A. 1	Pilmi	hesda, Ma phrey Fun	eral H	lome/
ñ	Depa Impo any is		1 XMm/).	the MC	0689	R	ockville,	Inc. 3	00 West 1	loni	Egomery A 20850-28	zenue,	,
			23a. Part1. Enter the disease, or com shock of heart failure. List only			Do not ent	er the mode of dyin	g, such as cardia	ac or respiratory ar	rest,	1	Approximate Interval Bet	е
	Pnysician		Immediate Cause (Final disease or condition	Cont	act		mshot		1 2 1 1	W	ad	Onset and I	Death
	/Medical Examiner		resulting in death)	Due to (or as	a conseque				1				
	Exammer		Sequentially list conditions,	b	-2-2-0-2-0-10								
17	ed sit	June	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a conseque	nos otj.							
111	be execut ician and burial-trar	Examiner	that initiated events resulting in death) Last	cDue to (or as	a conseque	ence of):		-					
68760,	cate be executed physician and the burial-transit			d									
687	= On es	edical		u									
Вох	eath cert attending	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregnancy				23d. Date of delive	ry	
	that the death cer ed by the attendir detached for use	Physician/N	in the past 12 months? 1 \subseteq Yes 2 \subseteq No	4☐Pregnant a			Other (specify)				Month	Day 1	/ear
P.0	at the	Phy	9 Unknown										
	as Dec	by	Part II. Other significant conditions of	contributing to death b	out not result	ing in the ui	nderlying cause giv	en in Part I.	23e. Dia to		use contribute to th	e cause of d ably 4 □U	
orc	w require been si should I	Completed							F		-		
Sec	e law has b	npl							24a, Was autop		24b. Were autor prior to cor death?	ssy findings a apletion of c	available ause of
Vital Records,									1 🔀 Yes	2 🗆 N		2 🗌 No	
Ζ		o Be	25. Was case referred to medical examiner?	Hospital:		0/0-4	Oth		eath (Check only o		77 OH 10 K		and 1
of		H= 1	1 X Yes 2 No 27. Manner of Death	1 ☐ Inpatie	iry 2	8b. Time of	I 3 DOA	4 Nursing	28d. Describe h		Other (Specify	at so	cere
ion	Attanding Ph r death. ector: After th by the funeral	atlor	1 □Natural 5 □ Pending 2 □ Accident investigatio	n 10/70/	/ //	Injury 3:401		k? Yes 2. X No	Deceas	ed	shots	elf	
Division	Attand ar death ector: A by the fi	Certification;	3 Suicide 6 ☐ Could not be determined	286. Place of m			eet, factory, office		28f. Location (S	treet a	nd Number or Rural	Royte Num	Srive
	s afte	Cert	Thomas	building, or	non	ne	_		Gaithe	156	ing, MI	ZOE	
	To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one) 1 ☐ Certifying Pt 2 ☐ Medical Exam	nysician: To the best niner: On the basis o and manner st	of examination	ledge, death on and/or in	n occurred at the tirvestigation, in my o	ne, date and plac pinion, death occ	e, and due to the curred at the time,	cause(s date an	s) and manner as st nd place, and due to	ated. the cause(s)
	To th within To the	Me	29b. Signature and title of certifier	1	1.		29c. Licens	e number			ate signed (Month, L	-	
			XXXX	WI	M			O.C.M.E.		Oct	ober 21,	2004	
-	2011		30. Name and address of person who	completed cause of o	death (Item 2			eet Ral	timore	Man	yland 212	01	
	Sta		31. Date filed (Month, Day, Year)		ar's Signatu		- Can Dil	COL, IXII	CHINTE!	TICLL	утики Z1Z	ΟŢ	
	Registı	ar	OCT 2 8 2004	1 min		19	Ana it						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year P_M AMY MEYER HARRIS OCT 2004 24 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday, 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛛 F Director 403-28-6866 95 NOVEMBER 21, 1908 IOWA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
snt: If item 27 is marked other than "natural", or Items 23e or 28e-f show ary or other traumatic event, I'm Wedical Examination multiped at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Directo MONTGOMERY BETHESDA MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4505 GRETNA STREET 20814 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: þ 3 X Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 BERTHA KRANBEER HENRY MEYER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3158 WENIG ROAD N.E. CEDAR RAPIDS, IOWA 52401 RAMONA H. CHAMBERLAIN/ DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State NOVEMBER 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If eny injury or once. 2, ¹ 4 □ Donation 5 □ Other (Specify) POSTVILLE CEMETERY 2004 POSTVILLE, IOWA 22. Name and Address of Facility ROBERT A. PUMPHREY FUNERAL 21. Signature of Funeral Service Licensee 20814 M00335 BETHESDA, MARYLAND 23a. Part1. Enter the disease of compositions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CHRONIC OBSTRUCTIVE PULMONARY DISEASE /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, I any, leading to infiniciate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Disc to (or as a consequence or) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-I Division of Vital Records, P.O. Box 68760. Physician/Medica 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown þ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has autopsy performed? certificate 1 Tes 2**X** No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: in by the 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a Certifie and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 25 04 0102201465 (VA) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER TODD R. LAROCK LCDR MC USN BETHESDA MD 20889-5600 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 2 8 2004 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 2004 34234 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician October 20, 2004 7:00 p^M George Michael Hauth /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Broadmead Cockeysville If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Director 212-03-4012 87 May 5, 1917 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County ?7 is marked other than "natural", or Items 23s or 28s-f show traumatic event, the Medical Exercise is ust be notified at 1 Yes 2 No Baltimore Cockeysville Maryland Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21030 13801 York Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Types 2 □ No
If Tes, Give
Year or Dates: 1944-45 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: þ 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Purchaser State Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Schmidtt Nettie Ε. George Michael Hauth, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any njury or other tra once. 2600 Tuscaroroa Trail, Maitland, FL Mrs. Marie Boruff 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 10/25/04 1 ■ Burial 2 Cremation 3 Removal from State Timonium, Maryland 4 □ Donenion 5 □ Other (Specify) Dulaney Valley Mem. Gardens 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 21093 Bryan W. Clary Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause Final Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or nije y that initiated events The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, nding physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No o 9□ Unknown 9 Unknown ď Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2 No ial or Attending Physician: 1 s after death.

I Director: After this certifical of in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes / 2 No Other: 4 Jurising Home 5 Residence 6 Other (Specify) Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 380 Date liled (Month, Day, Year) OCT 2 8 32. Registrar's Signature State Registrar

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		1 - For State Registrar	State of Maryland / Do	epartment of H	ealth and M	•	รูบบุ 3	4235
Physic	ian	1. Decedent's Name (First, Middle, La		41.		2. Date of Death Month	ay Year	3. Time of Death
/Medi	cal	4a. Facility Name (If not institution, giv	Tessa Hart Horva		Location of Death	uctober .	c. County of Death	22124
Exami	ner	-1 1 - 1	pkins Hospite	110-11	MORD	City	Baltimore	e City
Funeral		5. Social Security Number 6. S	7. Age (In yrs. last birth	day) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea		e (State or Foreign
Director		Usual Residence of Decedent	0 Yr	s. 5		October 12, 2		aryland
yland		10a. State 10b. County	10c. City, Town	or Location			10d.	. Inside City Limits
8a-fe	ctor		oward		olumbia			1 ☐ Yes 2 No
with the	Dire	10e. Street and Number		10f. Zip Code	04044	10g. 0	Citizen of What Country	
me 23	nerai	11145 Wood Elves wa	12. Was Decedent Ever in U.S.	13. Was Decedent of His If Yes, specify Cubar	21044 spanic Origin? (Spe	cify Yes or No-	U.S.A. 14. Race - American	Indian,
perrit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland perrit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heelth and Mental Hyglene. Important: If item 27 is marked other than "natural", or itame 23a or 28a-f show may injury or other traumatic event, the Medical Examinat must be notified at once.	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	If Yes, specify Cubar 1 ☐ Yes 2 No	n, Mexican, Puerto F Specify:	Hican, etc.)	Black, White, etc. Specify: W	: /hite
72 hc	Completed	15. Decedent's E (Specify only highest gra	ade completed) (ecedent's Usual Occupa Give kind of work done d	furing most of working	16b.	Kind of Business/Indus	try
within than	dmc	Elementary/Secondary (0-12)	College (1-4or 5+)	ife. DO NOT use retired)	er worked		never wo	rked
filed with Hygiene other than	4	n/a 17. Father's Name (First, Middle, Last)	neve		(First, Middle, Maide	en Sumame)	
y arr	To B	Stephe	n Horvath			_ Tara	Hart	
2 sho and l	ľ	19a. Informant's Name/Relationship (Type, Print) 19b. N	Mailing Address (Street a	and Number or Rural	Route Number, City	or Town, State, Zip Co	ode)
Tand 1 and 1 Heelth em 27 ther tr		Mr. Stephen Horvath	Father 20b. Place of D	11145 Wood E Disposition (Name of			nd 21044 Location - City or Town,	State
Pages nent of ant: If its		1 ■ Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Special	Removal from State	crematory or other place	10/2	22/2004		
perrit. Pag Department Important: I any injury o	4	21. Signature of Funeral Service Doe	nsele COIL	mbia Memorial F 22. Name and Addres	s of Facility		Clarksville, M	arylariu
Deer Perro		Mulality	plications that caused the death. Do no one cause on each line.	Slack F	uneral Home,	P.A. ike Ellicott Cit	MP 21043	oproximate terval Between
Physician /Medical gauge gauge as executed an and nial-transit	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Disseminate Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of	ed intra		Coagul ity	opathy 3	hows
ate be e	lical	•	d					
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aw rec	piete	HUDO-	tension			24a. Was an	24b. Were autopsy	findings available
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vital nec sicien: The law s certificate has b lirector, page 2 s	Be	25. Was case referred to medical examiner?	Harrier A		26. Place of Death			
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All or Atternal attended attended in by the	Certification:	3 Suicide 6 Could not be determined		n, street, factory, office	2	8f. Location (Street a City or Town, Sta	and Number or Rural Ro te)	oute Number,
To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the t	edicai		ysician: To the best of my knowledge, niner: On the basis of examination and/and manner stated.					
To t within To th	Σ	29b. Signature and title of certifier	me At-	29c. License		29d. D	ate signed (Month, Day	r, Year)
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/		30. Name and address of person you	completed cause of death (Item 23a) (T	MO RE ype, Print) to has Hopki	Mr ff assorta	1 600 N N	olfe St Balta	MANO WAA
St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	4 1		. 400 10 10	The state of the s	21287

Please Type or	Print in	Black Indelible Ink	. Ensure Al	l Copies Are Legible
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			For State Registrar	State	of Marylar	nd / Depa <i>Cei</i>	artment of H tificate of	lealth an <i>Death</i>	d Mental Hyg F	iene 20	04	34236		
ш	Physici	an	1. Decedent's Name (First, Middle	, Last)	Johnso	on			2. Date of Dea Month	Dav	Year	3. Time of Death		
	/Medic	al	Leroy 4a. Facility Name (If not institution	nive street and n		J11	4b. City, Town, o	or Location of D	OCTOBE	4c. County	004	3:20P M		
	Examin	ier	VA MARYLAND HE				PERRY F		odui	CECI				
	Funeral Director		5. Social Security Number 218-70-3711	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs. 83	. last birthday) Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Birth (Month, Day 02-23-	Year)	9. Birthp Cour	lace (State or Foreign try) S.C.		
and	A		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	cation				1	0d. Inside City Limits		
e Maryl	a-f sho	Director	Md.	NA		Balti	more					1X Yes 2 No		
th with th	23a or 20 al be no		10e. Street and Number 2715 E. Biddle	e Street			10f. Zip Code 2121	.3	ĺ	0g. Citizen of V USA	What Cour	try?		
UUSO hours after death with the Maryland	of Mental Hygiene. marked other than "natural", or Items 23s or 28s-1 show matic event. Its Medical Exercicer marke colling at	by Funeral	11. Marital Status X Never Married 2 Marr 3 Widowed 4 Divorced	Armed F	2 🗌 No live	'	Was Decedent of H f Yes, specify Cub 1 ☐ Yes 2 X No	dispanic Origin' an, Mexican, P Specify:	? (Specify Yes or No- uerto Rican, etc.)	Blac	e - Americ ck, White, Blac	etc.		
Z1Z13-0030 d within 72 hours af	"natur alical	leted	15. Deceden (Specify only highes	's Education t grade completed	")	16a. Deced	dent's Usual Occup kind of work done DO NOT use retire	pation during most of	working	16b. Kind of Bu	usiness/Ind	dustry		
CIZIZIO	giene. er than	Completed	Elementary/Secondary (0-12) 6th grade		(1-4or 5+)		abled			NA				
Maryland d 2 should be file	ental H) ked oth Ic event	To Be	17. Father's Name (First, Middle, Norman	Last)	Johns	son		18. Mother's	Name (First, Middle,		mith			
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a a	Health tem 27 other tra	3	Deborah A. Ev		20b.	Place of Dispo	sition (Name of		Baltimore	, MG. 20c. Location -	2121:			
altimore,	nent of ant: If i ury or		No Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (S	3 □Removal from pecify)	n State	-	ratory or other pla Forest		m. 10-26-0	4 Owi	.ngs l	Mills, Md.		
Balt	Department of H Important: If ite any injury or of once.		21. Six nature of Funeral Service	R. Wa	ltoy &	m	Name and Address	H. East	1101 E	ore, Mo . North				
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O. BOX of		Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown			l. Date of delivery Month Day Year								
ecords, P.O.	signed by	by	Part II. Other significant condition	ns contributing to	death but not re-	sulting in the ur	nderlying cause giv	en in Part I.				e cause of death?		
The law requires t	has been ge 2 shoul	Completed							24a. Was a autops	y	Vere autor prior to con leath?	osy findings available npletion of cause of		
		a	25. Was case referred to medical					26. Place of	1 ☐ Yes Death (Check only on	No 1	☐ Yes	2 No		
OT VITA Physician:	this cer al direc	ToB	examiner? 1 Tes 2 X No		Inpatient 2		1 JLI DOM	ner: 4 📉 Nursin	ng Home 5 Reside		ar (Specify)		
	h. After th funeral	tion:	27. Manner of Death 1 Manual 5 □ Pendin 2 □ Accident investig	9	of Injury nth, Day Year)	28b. Time of Injury	Wor	yat rk? Yes 2 □ No	28d. Describe ho	w injury occurr	ed			
DIVISION Lor Attending	after death Director: /	Certification;	3 Suicide 6 Could determined	not be 28e. Plac	ce of Injury - At h ding, etc. (Speci	nome, farm, str ify)	eet, factory, office		28f. Location (Si City or Town		er or Rura	Route Number,		
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·		1	· UUC	luv 1	Re		D38	950		OCTOBE	R 17,	2004		
	mx/		30. Name and address of person					VÇMEM	DEDDY DOTA	ירו או וויין	7f 7t 7t 7t 7t 7t 7t 7t 7t 7t 7t 7t 7t 7t	21902		
	Sta	ate	MANUEL RAMOS, I		Registrar's Sign	ature	II CARE S	TOTEM!	LEWYI POII	I PAR	TUAMD	21302		
	Regist	rar	mor 2	8 2004	hener	a p	1 son	18621						

State of Maryland / Department of Health and Mental Hygiena 1 - For State Registrar 34237 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 19, 2004 8:09 pM October Johnson Johnnie /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Landover 6812 Fairwood Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Sept. 19 1943 Halifax, N.C. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Min 1 X M 2 □ F Sept. 244-68-4496 61 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ir than "natural", or Itams 23c or 28a-f show the Medical Examinat must be notified at 1X Yes 2 □ No Director Landover Maryland Prince Georges 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States America Landover 6812 Fairwood Road death . Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: within 72 hours after 1 Never Married 21 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. Specify: Black ۵ 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 Heavy Equipment Operator Government Pages 1 and 2 should be filed nant of Health and Mantal Hygisint: If item 27 Is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ida Cotton Sherd Lee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20784 Maryland Shirley Johnson/Wife 6812 Fairwood Road Landover or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 1 Cremation 3 ☐ Removal from State permit. Page Department Important: If any injury of Fort Lincoln Crematory 10/26/2004 Brentwood, Maryland ⁴ 4 ☐ Donation 5 Other (Specify) 22. Name and Address of Facility
Fort Lincoln Funeral Home
3401 Bladensburg Road Br 21. Sig 111 Superal Service Licensee Man Wi E Brentwood Maryland 20722 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Lung Cancer Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the burial-transit Diabetes Mellitus that initiated events resulting in death) Last To tha Hospital or Attanding Physician: The law requires that the death certificate be exect Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician I for use as the buria Physiclan/Medlcal 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? detached for 4□Pregnant at time of death 5 Other (specify) 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1√2 Yes 2 □ No 3 □ Probably 4 □ Unknown Anemia Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No Yes 2 No 1 Yes certificate 26. Place of Death Check onl one Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 2 this 28a. Date of Injury (Month, Day Year) Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 25, 2004 D0043211 una 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1221 Mercantile Lane Largo, Maryland Rupa A Varma MD OCT 2 8 2004 37. Registrar's Signature 31. Date filed (Month, State Registrar

State of Maryland / Department of Health and Mental Hygier $00 L_{
m l}$ 34238 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2330 9 2004 10 Johnson Clinton /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center
5. Social Security Number 6. Sex, 7. Age (In yrs. last birth Baltimore Baltmore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2□F 48 218 72 6253 9/10/1956 MD Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City. Town or Location 10a, State 10b. County or 28a-f show rel', or items 23a or 28a-f shore Examiner must be notified at XXYes 2 No Directo Baltimore NA 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number U.S.A. 21217 2418 Reisterstown Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ★ Who If Yes, Give Year or Dates: 14. Race - American Indian, Black White etc. filed within 72 hours after 1 ☐ Never Married 25 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify Completed by 3 ☐ Widowed 4 ☐ Divorced Black "naturel". 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Construction Co. Construction Worker na 6th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be . Pages 1 and 2 should be fil tment of Health and Mental H tent: If item 27 is marked otl jury or other traumalic even Virginia Lee ၉ Leon Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3706 Mainship Way, Abingdon, Md 21009 Barbara Dyson-Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) permit. Page Department of Importent: If eny injury or once. Crematory Inc. 10/29/04 Baltimore, Md Metro 21. Signature 22. Name and Address of Facility
March F/H West of Funeral Service Licensee Part Enter the thease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21215 4300 Wabash Ave, Baltimore, Md Approximate Interval Between Onset and Death Immediate Cause (Final Physician Septic shock disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Ischemic bowel Sequentially list conditions, if any, leading to immediate cause. Enter Undarying Cause (Disease or injury Due to (or as a consequence of) Examine burial-transit The law requires that the death certificate be executed asystolic arrest that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. physician Physician/Medical hematemesis the as IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year jo in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached Ö 9 Unknown 0 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records. Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 No 2 No 1 🗌 Yes 1 ☐ Yes Division of Vital To the Hospitel or Attending Physicien: director, 26. Place of Death (Check only one) 25 Was case referred to medical Be examiner Other: Hospital: 2 No NZ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA $4 \square$ Nursing Home $5 \square$ Residence $6 \square$ Other (Specify) ၉ 1 🗌 Yes After thi funeral D te Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide hours after within 24 hours at To the Funerel D pelli 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier M. Men RESOO! 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. MEYER HUEFER TRIADELPHIA RD MD Phi) 13245 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 2 8 2004 Registrar

State of Maryland / Department of Health and Mental Hygien 200 L 34239 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October 23 2004 Pauline Eleanor Kressler 4:000m/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harrford Edgewood 1580 Harford Square Dr. A Court If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) August 18 1927 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 □ M 2√2 F 171 22 8725 77 Newside, PA Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r then "naturel", or Items 23s or 28a-f show the Modical Exampler must be nutified at Maryland Harford Edgewood 1 ☐ Yes 2√ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1580 Harford Square Dr. A Court 21040 LISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. þ White XX Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Seamstress Clothing Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William J Peters Edna M Blose 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1580 Harford Square Drive A Court Edgewood, Md. 21040 Elaine R Rohrer 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State injury or Union Church Cemetery October 28 2004 Lehigh Co., PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee EF Lassann Funeral Home PA 23a. Part. Enter the dial ase, or complications that church the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 11750 Belair Road Kingsville, Maryland 2108/ Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Rectal **Physician** ueard /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be exec Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed: certificate 2 110 or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 ☐ Yes 2 ☐ NO To true seed, within 24 hours after deam.

To the Funerel Director: After this c 2 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 1 Watural 5 Pending 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Descrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only ure and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signa October 25, 2004 045390 30. Name and address of person who comple ed cause of death (Item 23a) (Type, Pri.) COL # 200, Bel Air MD: IOH

DHMH 17 Rev 1/2001

State Registra 32. Registrar's Signature

208 2004

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 34240 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 8.50 PM **Physician** 25 2004 Brianna River Belmont Klein OCT /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Agnes Health Center Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Hours October 13,2004 Maryland N/A/Director 12 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d, Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other treumstic event, the Madical Examinar must be notified at 1 ☐ Yes 2X No Director Howard Ellicott City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8102 Main Street 21043 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 14 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than College (1-4or 5+) Elementary/Secondary (0-12) N/A N/A N/A 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Randy J. Belmont Allison D. Klein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8102 Main Street, Apt. A, Ellicott City, Md. 21043 Allison D. Klein Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Department of h Important: If its any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Crematory 10/28/04 Falls Church, VA. 22042 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lemmon Funeral Home permit. 10 West Padonia Road, Timonium, Maryland 21093 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dulmonary interstitial **Physician** days /Medical Due to (or as a consequence of): Severe respiratory distress syndrome
Due to (or as a conseduence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine weeks twin to twin transfusion attending physician for use as the buria Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part J. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 No 1 Yes 1 Yes 2 _ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 0 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending 1 ☐ Yes 2 ☐ No death. investigation irector: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours 🛮 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MD Attending Neonatoria 23368 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Agnes HealthCare, 900 Caton Apenile, Baltimare SIEW-JYU ONG 31. Date filed (Month, Day, Year) Registrar

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State of Maryland / Department of Health and Mental Hygiene 001 34241

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Baltimore.	permit. Pag Department Importent: any injury o		21. Signature of Funeral Salvice Lic	Entered to the second	All	County C	2. Name ar	nd Addres	s of Facilit	ty			
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ă	d for	Physiclan/M	in the past 12 months?	1☐Live birth 4☐Pregnant	at time of c		□Ectopic pi □ Other <i>(sp</i>					Month	Day Year
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rd	v require been sig should b	ed	Lumpha	avero	\mathcal{L}	VVhu	mu	ICA	17		1 🗆 Yes	2 DNo 3	Probably 4 Unknown
000	as be 2 sho	Completed	S/R Bin	W. K	VM	nogra	gal	/			24a. Was an autopsy	24b. Were prior t	autopsy findings available g completion of cause of
ď	Th ate h	Com									perform 1 Yes 2	ed2 death No 1□Y	?
of Vital Becords	Attending Physicien: The refeath. ector: After this certificate his by the funeral director, page	Be (25. Was case referred to medical examiner?					Lau	-	of Death	n (Check only one)	SON's
1	hysic this c	2	1 ☐ Yes 2 XNo	Hospital: 1 ☐ Inpa		ER/Outpatie		and the same	4 🗀 INU	ursing Ho	me der 28d. Describe hov		
2	ding Phy After thi funeral	lon:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of I (Month,	Day Year)	28b. Time Injury	or M	28c. Injur Wor 1 □	yat k? Yes 2. □		28d. Describe not	v injury occurred	
Divicion	death death the f	Certification:	2 Accident investiga 3 Suicide 6 Could no	ha -	Iniury - At h	ome, farm, s			.05 20		28f. Location (Str.	eet and Number or	Rural Route Number,
2	Oire Direction by	ertif	4 Homicide determin	28e. Place of building,	etc. (Speci	fy)	11001, 140101	y, omoo			City or Town,	State)	
	spite ours nerei	0		Physicien: To the be									
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical		aminer: On the basis and manner	of examina								
	To th within To th comp	Me	29b. Signature and the of certhier	ASCIR	FATVT	PROF	MED	c. Licens	e number	0	29	d. Date signed (Mo	onth, Day, Year)
	^		M. WI Ha	www/				D	7416	\mathcal{U}		10/25/	<i>U4</i>
-	18		30. Name and address of person were PETR HAW	NEC 1		m 23a) (Type	GRE C	ENE	E (TR	EET	, BALT	MORE,	MD
10	Sta Regist		31. Date filed (Month, Day, Year) OCT 2 8 200	4 Sept	strar's Sign	ature	Spon	li		-			

State of Maryland / Department of Health and Mental Hygien 34243 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Tyzell LEE 10 26 11:59 AM 2004 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hopkius Bayview Medical Cuter Baltilliere If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Month, Day, | 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Country) ALABAMA **Funeral** 238-40-3683 Usual Residence of Decedent 12 M 2 □ F Months Director filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Item 27 is marked other than "neturel", or Items 23a or 28a-f show other treumatic event, the Modical Examined must be notified at 10d. Inside City Limits Funeral Director 17 Yes 2 □ No MARVLAND 10e. Street and Number 10g. Citizen of What Country? 60 12. Was Decedent Ever in U.S. med Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 Married □Yes 2 No Maryland 21215-0036 1 ☐ Yes 2/2 No Specify: lf Yes, Give´` Year or Dates: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Hygiene. 6 THGRADE DRIVER 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) .. Pages 1 and 2 should be fill thent of Health and Mental H GEORGE LEE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Importent: If Item 27 Is any injury or other treu 60 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - Oty or Town, 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) REMATORY 22. Name and Address of acility 21. Signature of Funeral Service Licensee FUNE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Supele /Medical Due to or as a consequence of): **Examiner** 1 Tant Sequentially list conditions, 1-17, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Dualto for as a consequence of -transit to the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): burial-1 Box 68760, the as IF FEMALE: page 2 should be detached for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably Completed 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed of Vital 1 Yes 2 No 1 ☐ Yes 2 ☐ No funeral director. 25. Was case referred to medical 26. Place of Death Check onl one Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After ! Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Center, 4940 Eastern Avance Falhimore Eberley olius Hopkins 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2 8 2004 Registrar

			1 - For Registrar		/ Department of Health and Certificate of Death	Mental Hygie	
			1. Decedent's Name (First, Middle, L	ast)		2. Date of Death	3. Time of Death
	Physici /Medio		June Ma	rie Lewis		OCT. 2	Day 2004 06:30AM
	Examir	ıer	4a. Facility Name (If not institution, g		4b. City, Town, or Location of De		4c. County of Death
			HNNE Arundes 5. Social Security Number 6.	Medical Centers			AnneHrundel
	Funeral Director		577486488	Sex 7. Age (In yrs. la. 1	Yrs. Months Days Hours Mi		9. Birthplace (State or Foreign Country) 35 Wash. DC
	land land		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location		10d. Inside City Limits
	Mary I-f sh	ţo	MD AF		4nnaignlis		1 No
	th the	Funeral Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?
	ath wi	raic	1319 Wash	ington Dri	ve 21403		US
	er de	une	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	(Specify Yes or No- orto Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	I', or	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2' No If Yes, Give Year or Dates;	1 ☐ Yes 2 ♣No Specity:		Specify: Black
9	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. I marked other then "natural", or Itams 23a or 28a-f show umatic event, I'm Mudical Examiner must be notified at	ted	15. Decedent's	Education	16a. Decedent's Usual Occupation	16b	. Kind of Business/Industry
215	thin 7 e.	nple	(Specify only highest g	College (1-4or 5+)	(Give kind of work done during most of w life. DO NOT use retired)	orking	, ,
21	filed with Hygiene. other ther	Be Completed	12	2	Reg. Nurse		Medical
gu	ould be fill Mental H arked oth atic even	Be	17. Father's Name (First, Middle, Las	st)	18. Mother's N	ame (First, Middle, Maio	· ·
2	hould d Mer marke matic	၉	19a. Informant's Name/Relationship	Time Print do 1 1 a	+ V3	2 B. M.	cGarrah
Baltimore, Maryland 21215-0036	C 40 20 20		Vanessa Marie L	ewis Owens	19b. Mailing Address (Street and Number or A AI Rug Ave, Huntin	aton Park, C	y or Town, State, Zip Code) A 40255
ore	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3	Removal from State 20b. Plac	ce of Disposition (Name of	Date 20c.	Location - City or Town, State
ţį	thent of the tant: If ite		` 4 ☐ Donation 5 ☐ Other (Spec	eity) L(n)	coln Memorial Nov	,04,2004 51	uitland MD
Bal	permit. Departr Imports any inju		21. Signature of Funeral Service Lice	90999	22. Name and Address of Facility	ineral Se	ervices, Fac.
	TOTAL SECTION		23a. Fart1. Enter the disease, or con	mp tions that caused the death.	Do not enter the mode of dying, such as cardin	VW LUCCSI	Approximate
	Physician		Immediate Cause (Final	y one cause on each line.	C. / 1100	areat,	Interval Between Opset and Death
	/Medical		disease or condition resulting in death)	a. Dua to (or as a conseque	nce of):		crays
	Examiner		Sequentially list conditions.	. Sep519	5		days
	ed sit	lnei	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as a consequer	nce of):		
jd.	The law requires that the death certificate be executed at the bas been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due o (o as a conseq er	nce of);		dolp
8760,	ate be ex nysician he buria	icai E					
Ø	tificate ig phys as the			u.			
ŏ	leath certifica attending ph I for use as th	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnance 1 ☐ Live birth 2 ☐ Fetal de			23d. Date of delivery
.E	the at	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ Yo 9 ☐ Unknown	4☐Pregnant at time of deat 9☐ Unknown			Month Day Year
Division of Vital Records, P.O. Box	ires that the de signed by the a I be detached i	Phy		contributing to death but not resulting	ng in the underlying cause given in Part I.	23a Did tabasa	2 trop appropriate to the agree of death?
ds,	uires signe d be	Ω	Carcleon	1000 Aug	ing in the underlying cause given in Parci.	1 Tes	b use contribute to the cause of death? 2 📉 0 3 🗆 Probably 4 🗀 Unknown
Ö	w require been sign should b	lete	Po mo	Facoulo		24a. Was an	
Re	Physicien: The lav this certificate has al director, page 2	Completed	java.	/ www.q		autopsy performed?	
ital	ien: rtifica stor, p	BeC	25. Was case referred to medical		26. Place of De	ath (Check only one)	No 1 □ Yes 2 □ Ho
> >	hysic his ce I direc	To E	examiner?	Hospital: 1 patient 2 ER	O++ =	Home 5 Residence	6 ☐ Other (Specify)
o L	ing P	on:	27. Manner of Ceath 1 Natural 5 □ Pending	28a. D te o Injury 28 (Month, Day Year)	8b. Time of 28c. Injury at Injury Work?	28d. Describe how in	
Sio	Attendi death. ctor: A y the fu	icati	2 Accident investigated 3 Suicide 6 Could not l	ho -	M 1 Yes 2 No		
Div	ol or Attending Patter death. I Director: After to in by the funera	ertification;	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ite)
	pspite hours inerel y filled	aic	29a. Certifier 1 Cartifying P	hysician: To the best of my knowle	dge, death occurred at the time, date and place	e, and due to the cause(s) and manner as stated.
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifice completely filled in by the funeral director; sompletely filled in by the funeral director dir	ledicai	(Check only 2 Medical Exa	miner: On the basis of examination and manner stated.	and/or investigation, in my opinion, death occ	urred at the time, date a	nd place, and due to the cause(s)
	To To	Σ	29b. Signature and title of certifier	-+ /.	29c. License number	29d. D	Pate signed (Month, Day, Year)
	1	-	Junte	Merster	V(1) 1)08199	1	10/25/04
	り	1	30. Name and address of person who	completed cause of death (Item 23	Ba) (Type, Print)	۵ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	Trongous	rm W.	
	Registr	1.6	OCT 2 8 2004	Beneva &	don de		

DHMH 17 Rev 1/2001

	1	For State Registrar	State of Marylan		tificate of E	Death	Re	9. n2 0 0 4	34245
Physician /Medica		Decedent's Name (First, Middle, Land W. Lehr				0	Date of Death Month CTVBER	2 36 300 r	
Examine		a. Facility Name (If not institution, git ST. AGNES HE	FALTH CARE.		4b. City, Town, or BALTI	MORE		4c. County of Deal	<u> </u>
Funeral Director		214-20-9205	Sex 7. Age (<i>In yrs</i> . 1	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min. 1.0	Date of Birth Month, Day 05/19	26 Mar	thplace (State or Foreigning) yland
show ed at		Isual Residence of Decedent Oa. State 10b. County MD Howard		ty, Town or Lo	cation				10d. Inside City Limit
with the Nasa or 28a-f	Direct	0e. Street and Number 6334 Montgomery		<u> Tuge</u>	10f. Zip Code 21075	5		og. Citizen of What Co	
laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Manlal Hygiene. Is marked other than "natural; or Items 23a or 28a-f show roumatic event, the Medical Examination to Complete the Medical Examination of the Complete the Complet	Completed by Funeral Director	1. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 10/	14-	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 No	spanic Origin? (Specifi n, Mexican, Puerto Ric Specify:	y Yes or No- can, etc.)	14. Race - Ame Black, Whit Specify:Whi	te, etc.
215-00 thin 72 hours an "natural Medical E	ubleted t	15. Decedent's (Specify only highest g	Education	16a. Dece (Give life.		furing most of working)		16b. Kind of Business	·
Baltimore, Maryland 21215-0036 Dearnit. Pages 1 and 2 should be filed within 72 hours all popartment of Health and Mental Hygiene. Moortant: If item 27 is marked other than "natural; or any injury or other traumatic event, its Medical Examples.	e Q	12 7. Father's Name (First, Middle, La: Karl Lehr	st)	neat1	ing and Al	r Condition 18. Mother's Name (F Paulina	First, Middle, N		y Gu
Marylan d 2 should be lith and Mental 27 Is marked of r traumatic eve	2	19a. Informant's Name/Relationship Margaret M. Leh			-	and Number or Rural F			
Baltimore, Mispermit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other transpries.		Margaret M. Len 20a. Method of Disposition X□ Burial 2 □ Cremation 3 34 □ Donation 5 □ Other (Special Control of the Contr	□Removal from State	Place of Dispo	sition (Name of	Dat	9 2	20c. Location - City or	Town, State
Baltim permit. Pa Departmen Important: any injury once.		21. Signature of Fundral Sorvice Lic	ensee A Miber	(5 41	12 01d Co	ss of Facility Harry Olumbia Pk	Ellic	ott City.	MD 21043
Pnysician /Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	mplications that caused the dealty one cause on each line. CRYP a. Due to (or as a conse	TOGER	ter the mode of dyin	g, such as cardiac or r	espiratory arre	est,	Approximate Interval Between Onset and Death
Examiner times	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a conse	quence of):					
76(cal	that initiated events resulting in death) Last	Due to (or as a conse	quence of):					
P.O. Box 68 that the death certifical ed by the attending phi detached for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3	□Ectopic pregnancy □ Other (specify) _	/		23d. Date of de Month	olivery Day Year
P. d		Part II. Other significant condition			ınderlying cause gıv	en in Part I.	23e. Did tol	bacco use contribute	to the cause of death?
ds, Puires that is signed lid be det	D 77	CVA. CHR	anic Renal	FAILU	RE		1 □ Y	es 2□No 3□P	TODADIY + E-OTINITO
Records,	ompleted t		onic Renal Roid Cancer		RE		24a. Was a autops perfori	an 24b. Were a	autopsy findings availal completion of cause of
/ital Records, clan: The law requires the entificate has been signe actor, page 2 should be or	tion: To Be Completed by	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Matural 5 Pending	Hospital: 1 Inpatient 20 28a. Date of Injury (Month, Day Year)	?,	ont 3 DOA Othor	26. Place of Death / ier: 4 □ Nursing Hom-	24a. Was a autops perform 1 Yes	24b. Were a prior to death? 2 1 Ye	autopsy findings availa completion of cause of s 2 DNo
Sion of Vital transition of Vital transitions by the transition of	Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manne of Death 1 Natural 5 Pending investiga 2 Accident 3 Suicide 6 Could no determin	Hospital: 1 Impatient 2 [28a. Date of Injury (Month, Day Year) tion to be ed 28e. Place of Injury - At building, etc. (Special Control of the control of th	ER/Outpatie 28b. Time a Injury home, farm, s	ont 3 DOA Other of 28c. Injury Wor M 1 December 1 D	26. Place of Death (inter-death of the property at the propert	24a. Was a autops perion 1 Yes : Check only or e 5 Reside d. Describe his city or Town	24b. Were a prior to death? 1 Ye re) ence 6 Other (Sp. ow injury occurred	autopsy findings availa completion of cause of s 2 No ecify)
/ital		25. Was case referred to medical examiner? 1	Hospital: 1 Impatient 2 (Month, Day Year)	ER/Outpatie 28b. Time of Injury home, farm, s	ont 3 DOA Otto	26. Place of Death / iner: 4 Nursing Hominy at rk? Yes 2 No	24a. Was a autops perform 1 Yes : *Check only or e 5 Residud. Describe he could be	24b. Were a prior to death? 1 Ye ne) ence 6 Other (Spow injury occurred itreet and Number or Fin, State)	autopsy findings availal completion of cause of s 2 No acify) Rural Route Number, as stated. as to the cause(s)

State

Registrar

MCTAZA KAZMI M D

31. Date filed (Month, Day, Year)

OCT 2 8 2004

32. Registrar's Signature

ST. AGNES HEALTHCARE

DHMH 17 Rev 1/2001

			1 - State of Maryland / De State of Maryland / De Registrar	partment of Health and ertificate of Death	Mental Hygier	2004 34246						
			1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	3. Time of Death						
	Physicia /Medic		Flora Laro		October 2	' a a a a a a a a a a a a a a a a a a a						
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea	th	4c. County of Death						
_			775 Seawall Road	Essex () If Under 1 Year If Under 24 Hrs	S. 8. Date of Birth	Baltimore						
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Months Days Hours Mir	. (Month, Day, Ye	1						
	Director		213-20-1186 80 Usual Residence of Decedent		April 3,	1924 Maryland						
	yland		10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits						
	a-ts	cto	Maryland Baltimore Ess	ex		1 ☐ Yes 2 XNo						
	or 28	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?						
	ath w		775 Seawall Road	21221		U.S.A.						
	er de Itams	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	 Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 	specify Yes of No- ito Rican, etc.)	14. Race - American Indian, Black, White, etc.						
36	hours after death with the Maryland turel', or Itams 23e or 28e-f show of Exercit er coust be notified at	by F	If Yes, Give 3 ☒ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify: White						
21215-0036	2 hou	ted	15. Decedent's Education 16a. De	edent's Usual Occupation	16b	. Kind of Business/Industry						
215	within 72 ene. than "nai	Completed	(Specify only highest grade completed) (Gillife Elementary/Secondary (0-12) College (1-4or 5+)	re kind of work done during most of wo DO NOT use retired)	orking							
21	filed wit Hygien othar tha	Con		rt Order Cook		Diner						
D L	tal Hydrania	Be	17. Father's Name (First, Middle, Last)		ime (First, Middle, Maid	(en Sumame)						
Maryland	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or Itams 23e or 28e-1 show aumatic event, the Meulted Essrip or chast be notified at	2	Gechle	Margu	erette	Lang						
Ma	12 sh h and 7 Is n traun											
	1 and Healt am 2			Seawall Road Ba	ltimore MI	D 21221 Location - City or Town, State						
ğ	ages int of t: If it y or c		1 🗆 Bunai 2 💢 Cremation 3 🗆 Hemoval from State	,	3/2004 Fai	lls Church VA						
altimore,	ortan		21. Signature of Euroral Service Licensee	22. Name and Address of Facility	- Compression of the control of the							
ñ	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic en			Miller-Dippel 6415 Belair	Funeral Hor Road Balt	ne, Inc. imore MD 21206						
		23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
	- Pnysician		Immediate Cause (Final disease or condition	1 Intarction)	Onset and Death						
	/Medical		resulting in death) Due by (1 as a consequence of):			0.00						
8	Examiner		Se wentially list conditions b. Connary f	Henry Disease	se	5-6 mos.						
	ed sit	niner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.									
_	xecut and al-trar	Examin	that initiated events c. resulting in death) Last Due to (or as a consequence of):									
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289	ifficate g phy as the	a a	0.									
ŏ	death certifics attending plants as the	Physician/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death	B⊟Ectopic pregnancy		23d. Date of delivery						
m m	deat	sicis	in the past 12 months? 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death	Other (specify)		Month Day Year						
P.O.	res that the de signed by the a be detached f	Phy	9 Li Unknown	and the same of the Board	220 Did tobass	to use contribute to the cause of death?						
	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part i.		2 No 3 Probably 4 Onknown						
0	w require been si should b	eted	N. (N)									
Records,	elaw hast je 2 s	Completed	CVH		24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?						
a	n: Th licate r, pag		Preumothoras		1 ☐ Yes 2 🖼							
Vital	ding Physician: The In. h. After this certificate ha funeral director, page	o Be	25. Was case referred to dical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa	Othor	eath (Check only one) Home 5 = Residence	6 □Other (Specify)						
ō	Phy or this oral d	-	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	28d. Describe how in							
on	Attending r death. actor: After by the fune	atio	1 Matural 5 Pending (Month, Day Year) Injur 2 Accident investigation	M 1 ☐ Yes 2 ☐ No								
Division of	or Attendation of Diractor:	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)						
ō	tal or rs after al Dira	Cer										
	To the Hospital or Attent within 24 hours after death To tha Funeral Diractor: completely filled in by the	edicai	29a. Certifier (Check only 4 Deficient of the best of my knowledge, do 2 Medical Examiner: On the basis of examination and/or									
	the I tha I mplet	Med	one) and manner stated. 29b. Signature and title of certifier A	29c. License number		Date signed (Month, Day, Year)						
	To To		250. Signature distribution of the state of	D005.702	, 1	7/12/24						
,			30. Name and address of person who completed cause of death (Item 23a) (Ty)		-1 1	0/20/						
	10		Dr. Rita Mathur 9106 Philadelphia		MD 21237							
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature	mode Dartimore	<u> </u>							
	Regist		OCT 9 0 2004									

State of Maryland / Department of Health and Mental Hygiene 34247 State Registra Amend Item #17&18 Per FH G85 Certificates of Peath 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician Aldo Lago 11 p. October 16, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death **Examiner** Ellicott City 2707 Turf Golf Rd. Howard 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1 M 2 ☐ F 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Yrs. Director 516-28-0282 August 29, 1922 Italy Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits rei', or iteme 23a or 28e-f show Exandrer: sat be notified at 1 ☐ Yes 2 No Director Marvland Howard Ellicott City 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21042 U.S.A. 2707 Turf Golf Rd. permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturel; or Iteme 23 any injury or other treumatic event, the Madical Exportment: wat Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry Food Service Elementary/Secondary (0-12) College (1-4or 5+) Restauranteur 18. Mother's Name (First, Middle, Maiden Sumame) Casorati 17. Father's Name (First, Middle, Last) Be Lagomarsino Erina Gasrati Luigi ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2707 Turf Golf Rd. Ellicott City, Maryland 21042 Wife Ms. Patricia A. Lago 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Oremation 3 Removal from State
4 Donation 5 Other (Specify) All County Cremation Services, Inc. 10/18/2004 Sykesville, Maryland 22. Name and Address of Facility Slack Funeral Home, P.A 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto for as a echeequenee offi Examiner The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the ! IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy rmed? Yes To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 2 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. after death Director: 2 Accident 3 🗌 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined lilled in by 4 \(\text{Homicide} \) within 24 hours a To the Funerel L Sertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier ical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Actionaise, Mol flul 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® O.O.I.

			Amend Item,5 per I	nfor.G840 2/	1 a / Depa 23 / ©ei	artmen e b rtificat	it of F e of	nealth and l <i>Death</i>		gien e Reg. No.) 4	34	248
	Physici	an	1. Decedent's Nama (First, Middle, Last)						2. Date of De Month	ath Dav	Year	3. Time 9:30	of Death
V.	/Medic Examin	al	WILMA LUDEN 4a. Facility Name (If not institution, give st				-	4b. City, Town, or	Octobe Locetion of Death			J.0.	
Ĺ	Examili		Holly Hill Nursi	ng Home				Towson			ltimo		
	Funeral Director		5. Social Security Number 6. Sex 217-52-2864	7. Age (In yrs. 97	last birthday) Yrs.	If Under Months		If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da September	th (23, 1907)	9. Birthpla Counti Penn	ice (State y) 5 y] \/	ania
	yland h ow		10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10		City Limits
	Ba-f s	ctor	Maryland Baltimor	e	Luther	1				10. 0% ()			s 2XXNo
	ath with t	Funeral Director	10e. Street and Number 125 Dublin Drive				1093			USA		-	
020	pamit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haatth and Mantal Hygiane. Important: If Item 27 is marked other then "neturel; or Items 23a or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.	호	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Muldowed 4 □ Divorced	2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2(VNo If Yes, Give Year or Dates:		Was Dece if Yes, spe 1 □ Yes		lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No to Ricen, etc.)	Specify	e - America ck, White, e	tc.	
Baltimore, Maryland 21215-0020	within 72 hc ane. then "netur he Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)			dent's Usua kind of wo DO NOT u		pation during most of wor d)	orking 16b. Kind of Busine			ıstry	
land 2	ild be filed lantal Hygis ked other	To Be Co	17. Father's Name (First, Middle, Last) William Henry Lude	n	1	энста	Kei		ne <i>(First, Middl</i> e, ie Ritte		ne)		
lary	2 should and N is mar		19a. Informant's Name/Relationship (Typ			-			Rural Route Number, City or Town, State, Zip Code) IENVILLE, Manyland 21093				
e,	1 and Haalth em 27		William H Lindsay 20a. Method of Disposition	Son 20b. F	I ∠D I Place of Dispo pametery, crer				Date .	20c. Location -			
mor	Pages nent of I int: if ite		XX Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		id Ridg			ery	10/27/0	Pikes	ville	, Ma	ryland
Balti	parmit. Departri Importa any inju		21. signature of Funeral Service Licenses	News bis) 22	2. Name ar	nd Addre		litchell-W k Road Ba				
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the deat cause on each line.	h. Do not ent	er the mod	de of dyir	ng, such as cardiad	or respiratory a	rrest,		Approxim Interval B Onset an	ate etween
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x 68760,		resulting in death) Last											
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on of		tlon: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injui Wo			now injury occur			
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	To the within To the compl	Me	29b. Signature and title of certifier	_ ^ ^		29	c. Licens	se number		29d. Date signe		-	
			On Name and address of	polated as use of death (*)	7)	Drie*\	У	4110	4	(O	25	04	
	V		30. Name and address of person who cor	MD 782	-5	(01	k f	Zel To	4 3wson	MD	21	2 c	ory
1	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ALUITO A	la	- 1						

Wilma Lindsay

		1	State of Maryland / De State of Maryland / De	epartment of Health and Me Certificate of Death	ental Hygier Reg. r	2004	34249				
	Dhuaiais	_	Decedent's Name (First, Middle, Last)			Day Yeer	3. Time of Death				
	Physicia /Medic	al .	Vera Garneta Butz Moore	4b. City, Town, or Location of Death							
	Examin	٥.	4a. Facility Name (If not institution, give street and number) Oak Crest Village Care Center	Parkville		Baltimor	е				
	Funeral Director		5. Social Security Number 213-42-2555 6. Sex 1 □ M 2 ▼ 7. Age (In yrs. last birtho	Months Days Hours Min.	8. Date of Birth (Month, Day, Yee November	er) Cou	intry)				
	D P		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of	r Location			10d. Inside City Limits				
	Maryla -f sho	tor	Maryland Baltimore Parkv				1 ☐ Yes 2 X No				
	an or 28e	i Director	10e. Street and Number 8800 Walther Blvd.	10f. Zip Code 21234		yeer 2004 2:45 PM c. County of Deeth Baltimore 9. Birthplace (State or Foreign Country) 8,1910 Maryland 10d. Inside City Limits 1 Yes 2 No itizen of What Country? ited States 14. Race - American Indian, Black, White, etc. Specify: white Kind of Business/Industry edical In Sumame) or Town, State, Zip Code) Incisco, CA 94109 Inc					
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of health and Mental Hydiene. Importent: if item 27 is marked other than "naturel", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	y Funerai	Amed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes. Give	13. Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto F 1 ☐ Yes 2 No Specify:	cify Yes or No- Rican, etc.)	Black, White	, etc.				
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Maryland 21215-0036	wild be f Mental It arked of affic ever	To Be	William Butz		inda Hill						
Mar	d 2 sho		1,1,2	Nailing Address <i>(Street and Number or Rura)</i> L Van Ness Ave.,#30							
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Baltimore,	it. Pag ntment ntent: h njury o		*4 □ Donation 5 □ Other (Specify) Moreland	Memorial Park Oct. 2							
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	/Medical Examiner		resulting in death) Due to (or as a consequence of)	rillation heart disease	>		UPass				
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ital		Be C	25. Was case referred to medical examiner?	26. Place of Death							
	ng Phys fter this ineral dii	은	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outp	ne of 28c. Injury at 2	ne 5 🗌 Residence 28d. Describe how in		cify)				
Division	or Attend after death Director: /	Certification:	2 Accident investigation 2 Suicide 3 Suicide 4 Homicide 4 Homicide 4 Homicide 4 See. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Num City or Town, State)								
_	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attel completely filled in by the fune	Medicai Ce	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, 2 Medicel Exeminer: On the basis of examination and/and manner stated.	death occurred at the time, date and place, a or investigation, in my opinion, death occurre	and due to the cause ed at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)				
	To th within To th compl	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month	Dey, Year)				
,	. 1.			MD D05643	10	100/0	,				
'	70		30. Name and address of person who completed cause of death (Item 23a) (The Faulkner MD) 8000 Walffur	n Blud/Balto	MD 9	1234	1				
1	Sta Regist	ate	31. Date filed (Month, Day, Year) 2 8 2004 32. Registrar's Signature	& Souls			7				

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			1 - For Stete Registrar	State of M	laryland / Dep <i>Ce</i>	artment <i>rtificate</i>			nd M		giene Reg. No.	004	34250
	Physici	an	1. Decedent's Name (First, Middle,	Last)						2. Date of De		Year	3. Time of Death
	/Medi		ELBA L.	MENDEZ						ocTober	25	2004	10:50 PM
	Examir		4a. Fecility Name (If not institution, LAUREL REGIONAL	HOSPITAL		LAURI	EL	Location of				Inty of Death	RGES
	Funeral		5. Social Security Number	3. Sex 7. A 1 □ M 2√2 F	ge (In yrs. last birthday) 66 Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Da	h y, Ye <i>ar)</i>		place (State or Foreign http:// RTO RICO
	Director		217-40-1515 Usual Residence of Decedent	- A	00 113.					JAN . 8	,1938	PUEI	RIO RICO
	yland yow		10a. State 10b. County		10c. City, Town or Le	ocation						1	0d. Inside City Limits
	a-fsh	cto	MD ANNE AR	UNDEL	LAUREL								1 ☐ Yes 24 No
	or 28	Oire	10e. Street and Number			10f. Zip	Code				10g. Citizen	of What Cour	ntry?
	ath w 8 238	rai	3383 YELLOW SP				2072		1 0 10			S.A.	
	Item	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Marrie	12. Was Deceden Armed Forces	?					cify Yes or No Rican, etc.)		Race - Americ Black, White,	
036	ursaf	by	3 □ Widowed 4 □ Divorced	lf Yes 2 ☐ If Yes, Give Year or Dates		1 A Yes 2	2□ No	Specify:	PUER.	TO RICA	.N Spe	ocify: WH]	ITE
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show he Madical Examinar must be notified at	Completed	15. Decedent's (Specify only highest	Education grade completed)	16a. Dece	dent's Usua kind of worl DO NOT use	l Occupa	ation during most	of working	ng	16b. Kind o	f Business/Ind	dustry
121	within ne.	mpl	Elementary/Secondary (0-12)	College (1-4or	(5+)	DO NOT use MEMAKE)			O	√NED HO	ME
	filed v Hygie ther t		17. Father's Name (First, Middle, L	ast)	110.	TLITITAL	- IX	18. Mother	's Name	(First, Middle,			ME
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Mar	12 sh h and 7 Is m Iraum		19a. Informant's Name/Relationshi			_				Route Numbe			Code)
	1 and Healt am 2		ALLAN MENDEZ/ HU 20a. Method of Disposition	SDAND	20b. Place of Dispo	3 YELI osition (Nam	ie of			LAURE	_	20724 on - City or To	own, State
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Itam 27 is any injury or other tra <u>once</u> .		1 ☐ Burial 2 ☐ Cremation : 4 ☐ Donation 5 ☐ Other (Sp.		BALTWAS				0-27-	-04	LAURI	EL, MD	
alti			21 Signature of Funeral Service L		2	2. Name and	d Addres	s of Facility	FLEC	CKTFUNE	RAL HO	ME INC	7.
m	20 5 3		- Kempa	Dowart	7	601 SA	MDA	SPRIM	NG RI	LAUR	EL, M	20707	
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8760,	death certificate be executed be attending physicien and ad for use as the burial-transit or	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequence of): s a consequence of):								
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Division of Vital	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of linjury M 1 Yes 2 28c. Injury at Work? 28c. Injury at Work? 28c. Injury at Work? 28c. Injury at Work? 28c. Injury at Work? 28c. Injury at Work? 28c. Injury at Work? 28c. Injury at Work? 28c. Injury at Work? 28c. Injury at Work?							-	28f. Location (Street and Number or Rural Route City or Town, State)			l Route Number,
	e Hospita 24 hours e Funeral etely filled	Medical C	29a. Certifier 1 XCertifying (Check only 2 Medical E	Physicien: To the bes xeminer: On the basis and manners	t of my knowledge, deat of examination and/or in stated.	h occurred a vestigation,	at the tim in my op	ne, date and pinion, death	place, a	nd due to the old at the time, o	cause(s) and date and place	manner as st ce, and due to	ated. the cause(s)
	To the within To the complete	Me	29b. Signature and title of certifier	¢- ,				number			29d. Date sig	ned (Month, I	Day, Year)
	-		1 H15	oral w	9	J	02	315	8		OCTOB	ER 26,	2004
	Ai		30. Name and address of person w	no completed cause of	death (Item 23a) (Type,	Print)							
	10		R.G. BHOJRAJ, M 31. Date filed (Month, Day, Year)		ORMAN_AVE#	T-1	LAUF	REL, M	D 20	707			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2004 34251 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Yeer P **Physician** OCT JIMMY LEE MANION 23 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner NATIONAL NAVAL MEDICAL CENTER MONTGOMERY BETHESDA 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Funeral 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min. 1**X** M 2□ F 506-30-0727 75 Director 26, 1929 Nebraska July Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 show other traumatic evant, the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Director Montgomery Kensington 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6 death with 11107 Woodson Avenue 20895-1608 or Itams 23a United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 N Yes 2 □ No 1946-14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: þ 3 Widowed 4 Divorced 1971 Year or Dates: natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygient important: if itam 27 is markad other than any injury or other traumairs Federal Government 12 Cryptographer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Wallace Hayes Manion Jesse Wallene Roby 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean L. Manion / Wife 11107 Woodson Avenue, Kensington, Maryland 20895-1608 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State December 20, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2004 Arlington National Cemetery 1 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licensee le lotymosor M01305 23a. Part 1. Shier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CONGESTIVE HEART FAILURE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine executed burial-transit Due to (or as a consequence of): Box 68760, attending physician The law requires that the death certificate be Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. the detached 9 Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 □Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has autopsy rmea? 2X No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Inpatient 1 ☐ Yes 2X No 2 2 ER/Outpatient 3∏ DOA this funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After To the Hospital or Attanding I within 24 hours after death.
To tha Funeral Director: After 5 Pending investigation 1 X Natural 1 🔲 Yes 2 🗆 No filled in by the f 2 Accident 3 🗀 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar 29b. Signature and title of certifier

BRIAN D. SUSI

31. Date filed (Month, Day, Year)

30. N me and address of person who completed cause of death (Item 23a) (Type, Print)

USN

32. Registrar's Signature

LT MC

OCT 2 8 2004

29c. License number

books

0101235157 (VA)

29d. Date signed (Month, Day, Year) 10/25/2004

NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600

State of Maryland / Department of Health and Mental Hygiene 004 34252 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** David Mellon October 25, Ian 2004 7:42 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bethesda Montgomery Suburban Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
June 11, 1933 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1XM 2□F New Jersey 71 135-24-9697 Yrs. Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, It a Nedfeal Examiner must be indifficed at once. 1 ☐ Yes 2 No Director Chevy Chase Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20815 4515 Willard Avenue, Apt. 2209 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Myes 2 □ No Korean fyes, Give Year or Dates: War 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify: White 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Foreign Policy Advisor Oil Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Catherine Mulgrew James D. Mellon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4515 Willard Avenue, Apt. 2209, Chevy Chase, Maryland 20815 Victoria Mellon/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State October 28 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. 2004 1 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland Robert A. Pumphrey Funeral Home/Bethesda—Chevy Chase, Inc. 21. Signature Funeral Service Licensee M01305 ettell 7557 Wisconsin Avenue, Bethesda, Maryland 20815 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Ceseliva /Medical Due to (or as a consequence of): Examiner witin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of): Examiner burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 □Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 40 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗆 No 1 🗆 Yes Yes the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Depatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending Division 1 Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and the of certifier 29c. License number BR8777495 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road, Bethesda, Maryland 20817 Atul Rohatgi, M.D. 31. Date filed (Month, Day, Year) OCT 2 8 2004 32. Registrar's Signature State Roser oouts Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 34

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Baitimore, Maryiand 21215-0020 semit. Peges 1 end 2 should be filed within 72 hours et Department of Health end Mental Hygiene. Important: If item 27 ie marked other than "natural", or my injury or other traumatic event, the Medical Exemination.		21. Signature of Funeral Service		, 1		/ 2	2. Name and	Addre	ss of Facility	у			icia,	ridryrand
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ysician		. Decedent's Name (First, Middle,	Last)				2. Date of Dear	ith Day Yea	3. Time of Death
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State Registrar

10 Ending

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

OCT 2 8 2004

111 Penn Street, Baltimore, Maryland 21201

30. Name and addr-ss of person who completed cause of death (Item 23a) (Type, Print)

KORFLL

Registrar's Signature

Patriorit known as Chorles E. Mosser

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 9:02 PM October 2004 Charles Mosser /Medical 4a. Facility Name (If not institution, give street and number) Batime Ctty Town, or and If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Jan. 29, 1 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Sinai Hospital 01 N/A 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 6. Sex 1M M 2 ☐ F Birthplace (State or Foreign Country) 218-68-7101 Director 47 1957 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other then "neturel", or Items 23a or 28a-f ehow event, the Madical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12318 Boncrest Drive 21136 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ∏Yes 2 (No Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Estimator **Highway Construction** d 2 should be filed with and Mental Hygier 7 ie marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 0. Mosser 2 John Florence Chism 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Dep*rtment of Health a important: if item 27 ie any njury or other trau once. Reisterstown, Maryland 21136 <u> Hillary Mosser</u> Wife 12318 Boncrest Drive 20b. Place of Disposition (Name of cometery, crematory or other place)
Dulaney Valley 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) Memorial Gardens 10-28-2004 Timonium Maryland 21. Sig e of Runeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part1 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Subarachnoid hemorrhage Pnysician days /Medical Examiner Cerebral Aneurysm UNELLOWN Sequentially list conditions, it as y, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to for as a consequence of: Examine Due to (or as a consequence of): attending physician Box 68760 certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 🗌 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) les-T1565 October 24, 2004 and address of person who completed cause of death (Item 23a) (Type, Print) Nesl Sinai Hospitel of Baltimer 31. Date filed (Month, Day, Year) 32, Registrar's Signature OCT 2 8 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien Out 34257 . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 27, 2004 **Physician** 1:54 Ам VIRGINIA AGNES NOVIER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Greater Baltimore Medical Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, 01/13/ 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1921 1 □ M 2 🔀 F 218-74-6895 83 MARYLAND Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other then "naturel", or items 23e or 28e-f show treumatic event, the Nedical Example from the foother 1 ☐ Yes 2 No BALTIMORE MONKTON Director MD 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 15830 CARROLL RD 21111 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mentat Hygiene. em 27 Is marked other then "naturel", or Ite 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: WHITE þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12YRS College (1-4or 5+) HOUSEWIFE HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) VIRGINIA ATKINS CHARLES GERBER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ortent: If item 27 is RICHARD O'BRIEN(SON IN LAW) 3148 OLD YORK RD. WHITE HALL, MD. 21161. 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) ■ Burial 2 □ Cremation 3 □ Removal from State IMMANUEL EPISCOPAL10/29/2004 SPARKS, MD * 4 Donation 5 □ Other (Specify) permit.
Departr
Importe
eny inji 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HENRY W. JENKINS 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. SONS CO. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner physician and s the burial-trans that initiated events resulting in death) Last The law requires that the death certificate be execu Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions, contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2PINo or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No I Director: A investigation 2 Accident 6 Could not be determined 3 TSuicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours aff To the Funerel Di completely filled in To the Hospitel 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29ç. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles GEORGE EDON 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiens 1 - For State Registra 34258 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician Helen Christine Nickerson** 5:00a. October 19, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel Prince Georges Mariner Health of Laurel If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 F Months Days Hours Yrs Director 231-42-3380 October 12, 1936 Virginia Usual Residence of Decedent the Maryland 10d. Inside City Limits 10h County 10c. City. Town or Location item 27 is marked other then "naturel", or Items 23e or 28e-f show other treumetic event, the Modical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Howard Jessup 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20794 8337 Ashwood Rd. U.S.A Completed by Funeral death 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 should be filled within 72 hours after on and Mental Hygiene. is marked other then "naturel", or Iter Black White etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done du life. DO NOT use retired) Own Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dorothy Tally **Ernest Jenkins** 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Importent: If item 27 is n any injury or other treum <u>once.</u> 8337 Ashwood Rd. Jessup, Maryland 20794 Mr. Albert Nickerson Husband 20a. Method of Disposition
1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Chemintory * 4 ☐ Donation * 5 ☐ Other (Specify) 22. Name and Address Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter-the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician myocardial hours disease or condition resulting in death) /Medical Due to (of as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner as the burial-transit Due to (or as a consequence of): attending physician Box 68760 Physiclan/Medical IF FEMALE use a 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 Ø No į Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ Alzheimeris 1 Yes 2 No disease 3 Probably 4 Unknown hypothyroidusm 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? certificate has 1 ☐ Yes 2 ☐ No 1 Yes To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifice 25. Was case referred to medical examiner? Be 26. Place of Death Check on one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? 1 (ANatural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) MD 30. Name and addr of person who completed cause of death (Item 23a) (Type, Print) LAUREL, MARYLAND NE IMORE 32. Registrar's Signature State Registrar

cian dical	Decedent's Name (First, Mid Vernon		Milton	Owens		2. Date of Death	5 Day 2004 Par	34259
	4a. Facility Name (If not instituti				or Location of Death	10 2:	4c. County of Death	8:40p M
iner	2243 E. Chas				timore		NA	
ai or	5. Social Security Number 215–90–5709	6. Sex 11 M 2 ☐ F	7. Age (In yrs. last bir 42	thday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	rear) Cour	place (State or Foreign ntry) Md.
	Usual Residence of Decedent 10a. State 10b. Coun	ty	10c. City, Town	n or Location				Od. Inside City Limits
ctor	Md.	NA		Baltimore				X□Yes 2□No
Director	10e. Street and Number	G		10f. Zip Code	17	10	g. Citizen of What Cour	ntry?
Funeral	2243 E. Chas	12. Was Dec	cedent Ever in U.S.	212.		cify Yes or No-	USA 14. Race - Americ	an Indian,
/ Fun	1 Never Married 2 ☐ Married	If Yes, G	² X No	If Yes, specify Cub	an, Mexican, Puerto I	Rican, etc.)	Black, White, Specify: B1;	etc. ack
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9 Be	17. Father's Name (First, Middl	e, Last)	Ottona		18. Mother's Name	(First, Middle, Ma	Evans	
T ₀	Gene 19a. Informant's Name/Relatio	nship (Type, Print)	Owens 19b	. Mailing Address (Street		l Route Number,		Code)
	Mae Owens	Mother		751 W. Sara			, Baltimore	
	20a. Method of Disposition 1√□ Burial 2 □ Cremation		State	Disposition (Name of y, crematory or other pla			oc. Location - City or To	
ث	* ◆ Donation 5 ☐ Other 21. Signature of Funeral Service		Mt.	Zion Cem. 22. Name and Addre	10–30		ansdowne, bore, Md. 2	Ma. 21202
7	D Mea	des W	one-	March F.	D MANAGEMENT		North Ave.	
Examiner	shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Classe of high that initiated events resulting in death) Last	a	(or as a consequence of cor					Interval Between Onset and Death
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DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 0 34260 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Vear **Physician** Pulliam Madeline 10 1:20p 24 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heritage Nursing Home Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 X F 054-28-1480 Director 2-20-10 Va. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Y⊟Yes 2 No Director NA Baltimore Md. 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 7229 Orth Rd. 21219 USA , or Itams 23c Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. þ Specify: Black 3 ☑ Widowed 4 ☐ Divorced natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Other People Homes 4th grade 17. Father's Name (First, Middle, Last) Domestic is marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumetic event. 18. Mother's Name (First, Middle, Maiden Surname) Be (William Hardaway Mattie Dehaven 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia H. Marshall Neice 7229 Orth Rd., Baltimore, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) High Rock Bapt. Ch 10-29-04 Rice, Va. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 Bemand 1101 E. North Ave. March F.H. East Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease. Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical **Examiner** Scale (isly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine death certificate be executed use as the burial-transit and the attending physician Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death Live birth in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year be detached for 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 1 Yes 1 Yes 21 No tha Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Hospital: Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural Injury 5 Pending after death. 1 Tyes investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a 1 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Pay, Year) completed cause of death (Item 23a) (Type, Print) Mane and address inder Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar OCT 2 8 2004

				State of Maryland / De	partment of Health and Mertificate of Death	lental Hygie	ene2004	34261
				Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
		Physicia /Medic		Gordon W. Pearson		Month OCT	Day Year 23 2004	2:43 AM
		Examin		a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
				Gilchrist Hospile facility	Towson		Baltim	ove
		Funeral Director		5. Social Security Number 6.8 Sex $1 \boxtimes M$ $2 \square F$ 82 $7.$ Age (In yrs. last birthown $1 \boxtimes M$ $2 \square F$	Months Days Hours Min.	8. Date of Birth 06/14/19)	9. Birth Minn	place (State or Foreign intry) esota
	and	*		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	r Location			10d. Inside City Limits
	Mary	faho	ţŏ	Arizona Maricopa Surpri	se			1 🗆 Yes X X No
	with the	Department of Health and Mental Plygiene. Importent: If Itam 27 is marked other than "natural", or items 23s or 28e-f ahow any injury or other traumatic event, the Medical Examinar must be notified at once.	Funeral Director	10e. Street and Number 16501 El Mirage Road #806	10f. Zip Code 85374	100	g. Citizen of What Cou USA	intry?
	deat	ems 2	ner	11. Marital Status 12. Was Decedent Ever in U.S. Amped Forces?	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
10	36 s after	or It	by Fu	1 Never Married Amarried Februs 2 No WWII 3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes ŽŽ No Specify:			hite
2	5-0036	atural Eal Ea			ecedent's Usual Occupation	16	6b. Kind of Business/li	ndustry
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	2121	ygien ygien t, the	Con		Machinist		ederal Gov	ernment
(3)	Maryland	Mental Hy Irked oth	To Be	17. Father's Name <i>(First, Middle, Last)</i> Ernest E. Pearson		e (First, Middle, Ma C. Ditty		
104	Mary nd 2 sho	alth and I			ailing Address <i>(Street and Number or Rur</i> 01 El [.] Mirage Road #			
133	Baltimore,	of Hear fitam rothe		20a. Method of Disposition 1 □ Burial 2 Cremation 3 □ Removal from State 7 1 □ Removal from State 7 1 □ Removal from State	rematory or other place)		Oc. Location - City or T	
	time	ment tent: I jury o		`4 □Donation of □Other (Specify) Ralas C		_	gewater, Ma	
101	Ball	Depart Import any in		21. Signature Funeral Service Licensee	22. Name and Address of Fællinge 6160 OxonHill Roa	P. Kalas d Oxon Hi	s Funeral l ill, Maryla	Home PA and 20745
				23a. Part. Enter the disease or complications had caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final		or respiratory arres	it,	Approximate Interval Between Onset and Death
		nysician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Congestive head Due to (or as a consequence of)				Yeavs
	Ε	xaminer		(Years
	113	si ti	iner	Sequentially list conditions, if any, leading to immediate cause. Eine Underlying Cause (Disease or injury that initiated events cause.				
,	V 1 t and	n and	Examiner	resulting in death) Last C. Due to (or as a consequence of):				
	8760 ate be e	the bur	ical	d				
700	Box 68	been signed by the attending physician and should be detached for use as the burial-transit	Physician/Med		3 Ectopic pregnancy		23d. Date of deliver Month	rery Day Year
Kil	0. 8	y the a	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)		. X	
(t.	IS, P	igned to	by	Part II. Other significant conditions contributing to death but not resulting in the Chronic Obstructive Pulmonary disease		_	cco use contribute to	
V	Records	peen	Completed	estimate designative primarily district	-	24a. Was an		opsy findings available
7	Rec	8 8	dwc			autopsy	prior to co	ompletion of cause of
2	ital	tificat tor, po	0	25. Was case referred to medical	26. Place of Deat	1 ☐ Yes 2 h (Check only one)		2.2 No
2	of Vita	nis ce	ToB	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpa	Others			m) Hospice
F	Division of Vital	After thunera		27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) Inju 1 □ Pending	ry Work?	28d. Describe how	injury occurred	
111	isio	death	Icati	2 Accident investigation 3 Suicide 6 Could not be determined determined	M 1 Yes 2 No	28f Location (Stre	et and Number or Rui	al Route Number
0,	Div	after Dirac	Certification;	4 Homicide determined building, etc. (Specify)	Street, factory, office	City or Town,	State)	arriodio Nambor,
	Hospits	within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) Check only one)	eath occurred at the time, date and place, r investigation, in my opinion, death occur	and due to the cau red at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)
-	To the	within To the	Me	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month	Day, Year)
)			I know Polas inD	00061199		10/23/2004	
		10		30. Name and address of person who completed cause of death (Item 23a) (Ty Jason Black 6601 North Charles	s + Tax MA	,	21204	
		Sta Registr		31. Date filed (Month, Day, Year) OCT 2 8 2004 22. Registrar's Signature	Sports			

			For State Registrar	State o	f Marylar		artment of H rtificate of L		∕lental Hy	giene Reg. No.	2004	34262
	sicia edic		Decedent's Name (First, Middle, L. Mary	L.		Pf1u	g		2. Date of D. Month 10/22		, Year	3. Time of Death 2:00 A M
	min		4a. Facility Name (<i>If not institution, gi</i> 6805 Eilerson Str		mber)		4b. City, Town, or Clinto	Location of Death			County of Dea Ince Ge	
Fune Direc			UNKNOWN	Sex 1 □ M 2 XF	7. Age (In yrs. 84	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D 11/21/	ith 1919	9. Bir Ne	nthplace (State or Foreign ountry) WYORK
faryland ahow	107.00	or	Usual Residence of Decedent 10a. State 10b. County Marroy 1 and Drain and County	la ama a la		ty, Town or Lo						10d. Inside City Limits 1 ☐ Yes 🏖 ∑No
with the N	The ment	i Directo	Maryland Prince (10e. Street and Number 6805 Eilerson S			CII	nton 10f. Zip Code 20	735		10g. Citiz	zen of What C	
Iryland 21215-0036 should be filed within 72 hours after death with the Maryland to Mental Hygiene. markad other then "natural; or Itams 23a or 28a-f ahow	EXECUTIVE DAMP	by Funerai	11. Marital Status 1 Never Married 2 Married 3X_Widowed 4 Divorced	12. Was Dec Armed Fo 1 Yes If Yes, Gi Year or D	2 /1/N 0 ve		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or N Rican, etc.)		14. Race - Ame Black, Whi Specify:	
d 21215-0036 filed within 72 hours af Hygiene. thar than "natural", or	I B MEDICAL	Completed	15. Decedent's 8 (Specify only highest g Elementary/Secondary (0-12) 12	Education rade completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired Secre	furing most of worl)	king		nd of Business	Industry
aryland 2 should ba filed nd Mental Hygid markad othar	c event,	To Be C	17. Father's Name (First, Middle, Las	t)				18. Mother's Nam	nne Tim		Sumame)	
12 : 12 : 18 : 18 : 18 : 18 : 18 : 18 :		-	19a. Informant's Name/Relationship William Pflug / S	(Type, Print)		1.	ng Address <i>(Street a</i> Eilerson					Zip Code) 20735
altimore, M mit. Pagas 1 and 2 partment of Health portant: If item 27	ry or otner		20a. Method of Disposition XX Burial 2 □ Cremation 3 4 □ Donation	☐Removal from	State _ (Place of Dispo cemetery, crer	sition (Name of matory or other plac tion Cem.	e)	Date 5/2004	20c. Lo	cation - City or	Town, State Iaryland
Baltimol permit. Pagas Department of Important: If it	any inju		21. Signature Juneral Service Lice	alas	1.	6	2. Name and Addres	Géorge P Hill Roa	. Kalas d Oxon	Fune	eral Ho Maryl	ome P.A. and 20745
Physic	_		23a. Park. Enter the disease, or constitution of the control of th	mplications that y one cause of a	caused the deal							Approximate Interval Between Onset and Death
/Medi Examii		e	Sequentially list conditions, if any, leading to immediate	b	(or as a consec	hyper	mount	\	2			
wecuted and	II-tramsit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a consec	Myp	eremilio	Turlen	VIA			
18760, The cate be axecuted physician and	e me puris	edical E		d		Ma	bells -	mell	MO			
D.O. BOX 61 at the death certific by the attending p	ched for usa as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Mo 9 □ Unknown	1 Live	tcome of pregni pirth 2 Teta nant at time of c own	al death 3	Ectopic pregnancy Other (specify)			2	3d. Date of de Month	olivery Day Year
cords, P. w requires that been signed by	ald be deta	by	Part II, Other significant conditions	contributing to d	eath but not res	sulting in the u	nderlying cause give	on in Part I.		tobacco u		o the cause of death?
The la	pagez	Completed					y <u>un delendered de</u>		24a. Was auto perf 1 Yes	psy ormed?	24b. Were all prior to death?	utopsy findings available completion of cause of
Vita	alrector,	To Be	25. Was case referred to medical examiner? 1 □ Yes 2X No	Hospital:	Inpatient 2] ER/Outpatien	nt 3 DOA Othe	26. Place of Deal			□Other (Spe	ecify)
Division of lor Attending Phys after death. Director: After this	e runeral		27. Manner of Death 1 ★ Natural 5 □ Pending 2 □ Accident investigati		of Injury th, Day Year)	28b. Time of Injury	Work	rat c? Yes 2 □ No	28d. Describe	how injury	occurred	
DIVISIO ne Hospital or Attendi n 24 hours after death. na Funeral Director: A	n vo n be	Certification:	3 Suicide 6 Could not 4 Homicide determine	d 286. Place	e of Injury - At h ing, etc. (Speci	ome, farm, str fy)	eet, factory, office			(Street and wn, State)	Number or R	ural Route Number,
To the Hospital o	completely fille	edicai	29a. Certifier XX Certifying F (Check only ons) 2 Medical Ext	miner: On the b	e best of my kno asis of examina ner stated.	owledge, death ation and/or in	h occurred at the tim vestigation, in my op	e, date and place, pinion, death occur	and due to the red at the time	date and	place, and due	e to the cause(s)
To t To t	COL	Σ	29b. Signature and title of certifier		gellen	We		3826		29d. Date	signed <i>(Moni</i> 5/04	th, Day, Year)
	le		30. Name and address of person who Glenn Edgecombe,	M.D. 7	700 01d	Branch	Print) n Ave. B2	10 Clinto	on,MD.	20735		
Re	Sta gistr		31. Date filed (Month, Day, Year) OCT 2 8 20		egistrar's Signa	dature	Sparks	/				

State of Maryland / Department of Health and Mental Hygien 2004 34263 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** BEVERLY A. PORTER 1.15 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harborside Health Care Baltimore Baltimore City 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign September 6, 1947 Baltimore, Maryland Months Days Hours Min 1 ☐ M 2 🔀 F 220 48 8113 57 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic avant. the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10415 Bird River Road 21220 USA Itema 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after of Hyglene. othar than "natural", or Iter Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) N/Ă N/A N/A d 2 should be filed w h and Mental Hygier 7 ie marked othar th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Louis Joseph Porter Edith Eleanore Bevans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Itam 27 ie n any njury or other traun once. Louis J Porter (Father) 10415 Bird River Road Baltimore, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Marial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery October 25 2004 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland afure of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home Inc 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 7401 Belair Road Baltimore, Maryland 21236 Approximate Interval Between Onset and Death Immediate Cause (Final Physician Helder disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical as the t IF FEMALE: nse 23c. If yes, outcome of pregnancy
1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? certificate has 2 No 1 Yes 2 No 1 Yes To the Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient Other: 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA 4 X ursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 Watural 2 Accident death, 1 🗌 Yes 2 □ No investigation Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by after 4 | Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature and title of cedifier mode, Fld 21239. 30. Name and address of person who o completed cluse of death (Item 23a) (Type, Print) palli 31. Date filed (Month, CT 2 8 2004 32. Registrar's Signature State Registrar

			1 - For State Registrar		Marylan	d / Depa	artmen rtificate	t of H	ealth a	and M		eg. No.	04	34264
	Physici	an	Decedent's Name (First, Middle								Date of Deat Month	h Day	Year	3. Time of Death
	/Medic	cal	Margaret								Oct.	24	2004	4:00p M
	Examir	ier	4a. Facility Name (If not institution 3 Silent Meadow	-	iber)				Location o	of Death			ty of Death timore	
	Funeval		5. Social Security Number		7. Age (In yrs. I	last birthdav)	If Under		If Under	24 Hrs.	8. Date of Birth			
	Funeral Director		159-32-9796	1 □ M 2 □ F	64	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, May 10	1940	PA	lace (State or Foreign try)
	P.		Usual Residence of Decedent								7			
	show	2	10a. State 10b. County			y, Town or Lo							1	0d. Inside City Limits
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	with a or	Funeral Director		. C+			10f. Zip		020		, '	0g. Citizen o		iry r
	ns 23	era	3 Silent Meadow	12. Was Dece	dent Ever in U.	S. 13.	Was Deced		030 spanic Ori	igin? (Spe	ecify Yes or No-	US A	ace - Americ	an Indian,
9	ofter o	Ē	1 ☐ Never Married 2 Marr	Armed For ied 1 ☐ Yes	2 ₩ No						ecify Yes or No- Rican, etc.)		ack, White,	
21215-0036	within 72 hours efter deeth with the Marylend ene. then "neturel", or Items 23a or 28e-f show the Madical Examiner must be notified at	d by	3 Widowed 4 Divorced	If Yes, Give Year or Da	tes:		1 ☐ Yes 2	No No	Specify:			Spec	ity: W	hite
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121	within	dw	Elementary/Secondary (0-12)	College (1-	4or 5+)	Teacl	DO NOT us	e retired,				Educas	* :	
d 2	Hygie Hygie other		17. Father's Name (First, Middle,	<u> </u>		reaci	ner		18. Mothe	er's Name	(First, Middle, M	Educa		
Maryland	s 1 and 2 should be filed within 72 hours efter deeth with the Marylen I Health and Mental Hyglene. Item 27 is marked other than "natureit, or Items 23a or 28e-f show ther treumatic event, The Madical Examilier must be inalified at	To Be	John E. Mart	in					Ma	rgar	et C. L	arkin		
ary	2 shou and M is mar eumat	-	19a. Informant's Name/Relations	nip (Type, Print)		19b. Mailir	ng Address	(Street a			il Route Number,		n, State, Zip	Code)
	1 and 2 Health a iem 27 is		Joseph Edward	Purcell/h			Silent	Mea	dow	Ct.,	Cockey	sville	, MD	21030
Baltimore,	of He		20a. Method of Disposition 1 XBurial 2 Cremation	3 □Removal from S		lace of Dispo emetery, crei	nsition (Nan	ne of ther place	9)	10/2		20c. Location	- City or To	wn, State
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Bal	permit. Pages 1 a Department of Hes importent: if Item any injury or othe	1	Bryan W.	Clary	ref	L	emmoi 10 W.	ר Fu Pad	nera donia	l Hoi Rd.	me of D	ulaney nium,	Valle	ey Inc.
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that da only one cause on	used the death ich line.	n. Do not ent	er the mode	e of dying	, such as	cardiac o	or respiratory arre	est,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Einal disease or condition resulting in death)	_a Co s		14	art		1 0	15	ease			30-001s
	/Medical Examiner		Todaking in dodiny	Due to (d	or as a consequ	uenca of):		(1
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o,	be executed siclen and burial-transit		resulting in death) Last		or as a consequ	uence of):								
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Вох	ath co	ian	23b. Was decedent pregnant in the past 12 months?		th 2 Fetal	death 3	Ectopic pre						ate of delive	ry Day Year
	at the de by the o	ysic	1 □ Yes 2 Ø No 9 □ Unknown	9□ Unkno	int at time of de wn	eath 5L	Other (spe	эспу)						
, P.O	es that igned by be deta		Part II. Other significant condition	ens contributing to de	ath but not resu	ulting in the u	nderlying ca	iuse give	n in Part I.		23e. Did tob	acco use cor	ntribute to th	e cause of death?
Vital Records,	quires n sign	ed by	obesity, c	pronic	0654	weti	re 1	pre	dise	ase	1 📝 Ye	s 2 No	3 Proba	ably 4 Unknown
00	aw require as been sli 2 should b	Completed						J			24a. Was ar		. Were autop	sy findings available
Ä	The la ate ha page	mo:									autopsy perform 1 Yes 2	red?	death?	npletion of cause of 2⊠No
ita	ician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?						26. Place	of Death	Check on one			
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n	ding P. h. After t funera	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pendin		f Injury Day Year)	28b. Time of Injury		Bc. Injury Work			28d. Describe ho	w injury occu	rred	
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Division	or Attenation after deati	Certification:	4 Homicide determ	ined 286. Flace of buildin	of Injury - At ho g, etc. (Specify	r)	eet, factory	OTICE		ĺ	28f. Location (Str City or Town		ber or Hurai	Houte Number,
	spite		29a. Certifier 1 Certifyin	g Physician: To the	best of my know	wledge, death	n occurred a	at the time	e, date an	d place, a	and due to the ca	use(s) and m	nanner as sta	ated.
	To the Hospitel or A within 24 hours after To the Funerel Direct completely filled in by	edicai	(Check only 2 Medicat	Examiner: On the ba	sis of examinat	tion and/or in	vestigation,	in my op	inion, dea	th occurre	ed at the time, da	te and place	, and due to	the cause(s)
	To the To the Comp	Ä	29b. Signature and title of certifier				29c.	License			29	d. Date sign	ed (Month, E	Day, Year)
)				MA	wo			D	(11)	4		10-	260	4
	10		30. Name and address of person	who completed cause	of death (Item	23a) (Type,	Print)			-				
	<u>()</u>		Theodore C. H 31. Date filed (Month, Day, Year)		. 78	25 Yo	rk Ro	١., :	Tows	on,	MD 2120	14		
	Sta Registr			8 2004			4							
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State of Maryland / Department of Health and Mental Hygie 2004 34265 1 - For State Registra Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Edmond Year Physician 500 10 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore, MD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

JAN. 14, 1927 Johns Hopkins Care Center Belt more City 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F 220-20-1571 Yrs. Director 77 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 show the Medical Examiner must be notified at 1 Yes 2 No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 238 11 S. COLLINGTON AVENUE 21231 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or Itams filed within 72 hours after with the Hygiene. Where then "natural", or Italian 1√ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: þ Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) BUILDING INSPECTOR BALTIMORE CITY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any njury or other traumatic event <u>once.</u> Be THEODORE PENSKI UNKNOWN ANNA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VICTOR LANCELOTTA/FRIEND 10 E. LEE STREET, BALTIMORE, MD. 21202 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XBurial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) STANISLAUS CEM. 10/27/04 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
LILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTO., MD. 21231 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Ventricular Arrythmia minutes /Medical Due to (or as a consequence of): Examiner Years schemic Cardio myo pathy Sequentially list conditions, if any, bading to initial data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requence of Examiner burial-transit Years Loronary Due to (or as a consequence of): the attending physician Box 68760 rears athero sclerosis Physician/Medical the as 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) 4☐Pregnant at time of death ☐Yes 2☐No Division of Vital Records, P.O. 9 Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Enephalo pathy 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Fibrillation autopsy performed: this certificate 1 ☐ Yes 2 ☑ No 2.01 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death the 6 Could not be 3 Suicide To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 & Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10/26/2004 D47479 Seem 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. Beamer THE Gertatrics, 5505 Hopkins Baymen Circle, Baltimere MD 21229 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			1_ State	artment of Health and Mental Hygi	ene2004 34266
			Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of Death	3. Time of Death
	Physici /Medic		MADELINE J. DZIERWA ROCK	Month October	25, 2004 10:00 PM ^M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Е	_		Greater Baltimore Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Towson If Under 1 Year If Under 24 Hrs. 8 Date of Birth	Baltimore
	Funeral Director		213-32-9751 1 M 2 F X 87 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Days Hours Min. Feb 22	
Ţ	0		Usual Residence of Decedent		
970	show	J.	10a. State 10b. County 10c. City, Town or Lo		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
a t	28e-f	Director	Maryland Baltimore County Balt	inore	g. Citizen of What Country?
r regit	38 01	ΙΩ	415 Regester Avenue	21212	USA
100	ems 2	Funerai		Was Decedent of Hispanic Origin? (Specify Yes or No- lf Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
00	or It		1 Never Married 2 Married 1 Tyes 2 k7 No	1 ☐ Yes 2 ☐ No Specify:	Specify: White
ILZ I 3-0030	s I am a should be men whill it a hours after beath with the waryan Health and Menhall Hygiene. I Health and Menhall Hygiene. I the Azi is marked other than "natural", or items 23e or 28e-1 show other traumetic event, Ira Madical Examinat must be natified at	Completed by	15. Decedent's Education 16a. Deced	dent's Usual Occupation	6b. Kind of Business/Industry
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5	marked	우	Karol (Charles) Dzierwa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailir	Viola ng Address (Street and Number or Rural Route Number)	Blachowicz City or Town, State, Zip Code)
Na S	alth ar 27 is r trau			rictoria Falls Court, Spart	, , , , , , , , , , , , , , , , , , , ,
e e	of Hea		20a. Method of Disposition 20b. Place of Dispo		0c. Location - City or Town, State
	rag ment ant: 1 ury o		1 \ Burial 2 \ Cremation 3 \ Removal from State '4 \ Donation 5 \ Other (Specify) Most Ho1	y Redeemer 10/30/2004	Baltimore, Maryland
	Definit. Fage Department o Important: If any injury or once.		21, Signature of Funeral Service Licensee 22	Name and Address of Facility Titchell-Wiedefeld Funeral	
			Martin D. Lawson 23a. Part 1. Enter the disease, or complications that caused the death. Do not en		Maryland 21212
n			shock, or heart failure. List only one cause on each line. Immediate Cause (Final	14-16-16-16-1	Interval Between Onset and Death
	hysician /Medical		disease or condition resulting in death) a	to way placeme	St 2 days
E	Examiner		Sequentially list conditions, b.	fall 32/0.	Qu' l
Ţ	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	O CO	
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	attend for us	ian/	In the past 12 months?	Ectopic pregnancy	23d. Date of delivery Month Day Year
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The law requires that the death	gned b		Part II. Other significant conditions contributing to death but not resulting in the un	, ,	acco use contribute to the cause of death?
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necords,	has be e 2 sh	Completed by	renal facture, CHF, Ly	mphoma 24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
			atrial frollation		No 1 ☐ Yes 2 ☐ No
VISION OF VITAL	s certif	o Be	25. Was case referred to me lical examiner? 1 ★ Yes 2 □ No	26. Place of Death (Check only one) at 3 DOA Other: 4 Nursing Home 5 Residen	
5 å	gring er this ieral c		27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injury at 28d. Describe how	vinjury occurred
	eath. or: Af	catic	2 Accident investigation 19123104 10	AM 1 Yes 2 XNO The fee	Il at home
	Ifter di Direct in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office 28f. Location (Stre	
O the Moenitel or	to the roughten or Attention of the within or within 24 hours after death. To the Funeral Directors After the completely filled in by the funeral		29a. Certifier 12 Certifying Physicien: To the best of my knowledge, death		ses les Uvenne 21212
7	n 24 h	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or in one)	vestigation, in my opinion, death occurred at the time, date	e and place, and due to the cause(s)
Ė	Withir Comp	ž	29b. Signature and title of certifier		d. Date signed (Month, Day, Year)
	_		Jeorge Karklar MD	· ·	10/27/200%
1	3		30. Name and address of person who completed cause of death (Item 23a) (Type. CEDRCE M. KARICAM D 31. Date filed (Month, Day, Year) OCT 2 8 2004	Print 65 N. Charle + St. 136	SIS TOWSON 2120
	* Sta	ite_	31. Date filed (Month, Day, Year) 32. Registrar's Signature	frank!	modes
	Registr		31. Date filed (Month, Day, Year) 8 2004 32. Registrar's Signature	gives	

			For State Registrar	State of Marylar		artment of H		d Mental H		2004	34267
			Decedent's Name (First, Middle, Last)					2. Date of I		Year	3. Time of Death
	Physicia /Medic		MAUDE RUNYEN					OCTOBE		2004	8: 35 ^M
):	Examin		4a. Facility Name (If not institution, give sto CASEY HOUSE HOSPIC			4b. City, Town, or		eath		County of Death	
			5. Social Security Number 6. Sex	7. Age (In yrs.	last hirthday)	ROCKVILLI	If Under 24	Hrs. 8. Date of 8		ONTGOME	RY place (State or Foreign
П	Funeral Director	Ì		v 2□x 88	Yrs.	Months Days		vin. (Month, I	Day, Year) • 191	MAPR4	ZZAND
	ס		Usual Residence of Decedent				ll	1 110.7	, 1)1		
	arylan ahow	_	10a. State 10b. County MONTGOMERY	_	ty, Town or Lo						10d. Inside City Limits 11√2 Yes 2 □ No
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	with the control of t	0	15009 PEACHSTONE I	OR.		20905			U.S.A		y.
	within 72 hours after death with the Maryland ene. than "natural", or Items 23c or 28a-f ahow he Medical Exercities must be rodified at	Funerai	11. Marital Status	2. Was Decedent Ever in U	.S. 13.	Was Decedent of Hi	ispanic Origin	? (Specify Yes or I		4. Race - Ameri	
9	after or Ite	Fu	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 Å No If Yes, Give		If Yes, specify Cuba 1 ☐ Yes 2X No	Specify:	deno Alcan, etc.)		Black, White, Specify:	etc.
8	ural',	d by	3 Widowed 4 Divorced	Year or Dates:						WH	ITE
2	n 72 l	Completed	15. Decedent's Educi (Specify only highest grade	completed)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of	working	16D. KIN	d of Business/In	idustry
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멀	e filed al Hyg I othe vent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Midd AN V. WI	le, Maiden S	Sumame)	
ylaı	ould b Ments arked atic e	To	B.F. GARDINER								
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan tt of Health and Mental Hygiene. If item 27 Is marked other than "natural", or Items 23c or 28a-f ahow or other traumatic event, Ite Medical Evanter must be rollined at		19a. Informant's Name/Relationship (Typ) VIRGINIA RILEY/DAUG			ng Address (Street a					o Code)
	1 and Healt Iem 2		20a. Method of Disposition	20b. I	Place of Dispo	BLUEFORD sition (Name of		NSINGTON. Date	MI) 2 20c. Loc	US95 ation - City or To	own, State
nor	ages ant of th: If it		1 Burial 2 Cremation 3 Re 1 Donation 5 Other (Specify)	moval from State	cemetery, crei ION CE	matory`or other plac METERY		-26-04	RIIR	TONSVIL	TE MD
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Juneral Service Licenses	· i	22	2. Name and Addres	s of Facility	FLECK FU	JNERAL	HOME, I	NC.
Ö	Per La Company	0 10	- Xenya Ste	wart		601 SANDY				MD 2070	7
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the dea cause on each line.	th. Do not en	ter the mode of dyin	g, such as ca	rdiac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician	Ŷ W	Immediate Cause (Final disease or condition resulting in death)	HYPERTENSI	VE CAR	DIOMYOPAT	HY				Onsor and Doam
	/Medical Examiner		1650nting in death)	Due to (or as a consec	quence of):						
	€ _	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec	quence of):						
	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
Ö,	death certificate be executed e attending physician and of for use as the burial-transit	I Ex	resulting in death) Last	Due to (or as a consec	quence of):						
8760,	cate be	dical	d.								
9	leath certific attending pl	/Me	IF FEMALE: 23	c. If yes, outcome of pregn	ancy				2	3d. Date of deliv	erv
Вох	atten d for u	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of	al death 3	□Ectopic pregnancy □ Other (s <i>pecify)</i>			. -	Month	Day Year
Ö.	the che	hysi	9 Unknown	9□ Unknown							
s, P	S E 0	by P	Part II. Other significant conditions cont	ributing to death but not re	sulting in the u	inderlying cause give	en in Part I.				he cause of death?
ecords,	w require been sig should b	ted				· · · · · · · · · · · · · · · · · · ·		- 1[」Yes 2L	X[No 3∐ Prol	oably 4 Unknown
ecc	aw as b	Completed						24a. Wi	as an topsy rformed?	24b. Were auto prior to co death?	opsy findings available empletion of cause of
al B								1 ☐ Yes	2 X No	1 Tes	2 No
Vital	Physician: This certifical	o Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \)	ospital: 1 🗌 Inpatient 2 🗆	ER/Outpatie	nt 3 DOA Othe	or	Death (Check onling Home 5 ☐ Re		v ther (Specia	HOSPICE
of		\vdash	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of		v at	28d Describ			97
ion	Attending Phy r death. ector: After this by the funeral c	atio	1 Natural 5 Pending 2 Accident investigation	(World, Day You)	Injury		Yes 2□No				
Division	or Attend after death Director: /	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci		reet, factory, office		28f. Location City or 7	(Street and own, State)	Number or Run	al Route Number,
	lospital of hours all uneral D	Ce	29a. Certifier 1 Certifying Physi	cian: To the best of my kn	owledge deat	th occurred at the time	ne date and r	place and due to the	(2/159/2)	and manner as s	tated
	T 4 h m	edical		er: On the basis of examin and manner stated.							
	To the To the Complet	Me	29b. Signature and title of certifier	110		29c. License	e number		29d. Date	signed (Month,	Day, Year)
			attet	the		D 4	1121	8	10/	23/0	4
	U		30. Name and address of person who cor		m 23a) (Type,	Print)				7	7
	10		CHARLES HARRISON, M 31. Date filed (Month, Day, Year)	I.D. 6001 MU 32. Registrar's Sign	NCASTE	R MILL RD	• ROCK	VILLE, M	208	55	
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			UUIAGE	X X 12		1	-				

State of Maryland / Department of Health and Mental Hygien 2004

34268

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2:00A M October 14 2004 Tracey Randolph James /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George Laure1 7612 Lexington Avenue | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. July 20, 1929 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 **⊠** M 2 □ F 75 Bolivia, N.C. Yrs. 243-36-2263 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show r then "natural", or itams 23a or 28a-f shov the Medical Examinar must be collified at Laurel Prince George Maryland 1 Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20707 7612 Lexington Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Black by 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Miller and Long d 2 should be filed within the and Mental Hygiene.
7 is marked other then "1 Elementary/Secondary (0-12) College (1-4or 5+) Steel Foreman Construction Company Ninth 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Lousianne Knight Pete A. Randolph 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) 7612 Lexington Avenue, Laurel, Maryland 20707 permit. Pages 1 and 2 Department of Health a. Important: If Item 27 is eny injury or other trau once. Jennifer Tracey Randolph/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition x⊠Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland National Mem Oct 22,2004 Laurel Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert G. Mason Funeral Home, 21. Signature of Funeral Service Licensee 1661 Good Hope Road SE, Washington DC 20020 MO1111 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 10 Months Metastatic Adenocarcinoma Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of) Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month ó in the past 12 months? 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, Diabetes Mellitus 3 XProbably 4 □Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Stroke 24a. Was an cate has autopsy performed? 1 Yes 2 No Hospital or Attending Physician: certific 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2₺ No 2 ER/Outpatient 3 DOA (his funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. М 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature D00754 October 22, 2004 impleted cause of death (Item 23a) (Type, Print) 7525 Greenway Center Drive, Greenbelt MD 20770 Thomas A. Bensinger

Registrar

31. Date filed (Month, Day, Year) 2 8 2004

32. Registrar's Signature

ORIGINAL

State

State of Maryland / Department of Health and Mental Hygiene 34269 Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2004 **Physician** Month Ruffin Bernard 20 7:30p/Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** l Morrislea Court Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1**X**]M 2□ F 219-18-5485 Yrs Director Md 81 9-6-23 Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other treumstic event, the Madical Examinar must be indiffed at 1 XYes 2 ☐ No Director Md. NΔ Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? l Morrislea Ct. 21234 USA Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1. Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel 10th grade Steel Cutter permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any injury or other treumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Ruffin Rose Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Estella Ruffin Wife l Morrislea Ct., Baltimore, Md. 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. 10-28-04 Owings Mills, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 Bemond March F.H. East 1101 E. North Ave. 10MBOZ Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** HYPERTENSIVE CARDIOVASCULAR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of). Examine burial-transit Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ed by the atter in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð VAS CULAR 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? OBSTRUCTIVE autopsy performed? 2 No 2 Z No 1 ☐ Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: al or Attending P s after death. I Director: After After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funerel Di 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier 302 mille 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THOMAS MILLS DATE FILED STREET OCT 28 MAIDEN CHOICE LANE 32. Registrar's Signature State 2004 Registrar

			For State	State of Ma	aryland / [Department of I Certificate of	Health and M			34270
			Registrar 1. Decedent's Name (First, Middle, Las	st)		Certificate of	Death	2. Date of Deat	eg. No.	3. Time of Death
	Physicia /Medic		Ella		Rose			Proter	23 2004	8:45D M
	Examin		4a. Facility Name (If not institution, give	street and number)	andal	4b. City, Town,	or Location of Death	1/	4c. County of Deatl	1
			5. Social Security Number 6. S	eral Hu	5/1/U/ o (In yrs. last bin	thday) If Under 1 Year	OFC (17	8. Date of Birth	NA O Side	(0)
	Funeral Director			ом 2√2 F 7. Age 45		Yrs. Months Days		(Month, Day,		nplace (State or Foreign untry)
7			Usual Residence of Decedent	7.						
daath with the Marcland	show	7	10a. State 10b. County	7.70	10c. City, Town					10d. Inside City Limits 1X Yes 2 □ No
φ 2	28e-f	ecto	Md. No. 10e. Street and Number	IA	Ba	altimore		10	0g. Citizen of What Co	
<u> </u>	30 or	0	1208 Myrtle Ave.			212]	17		USA	
	ems 2	Funeral Director	11. Marital Status	12. Was Decedent E Armed Forces?	ever in U.S.	13. Was Decedent of I		cify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
5-0036	"naturel", or ltems 23e or 28e-f show edical Exeminat must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married A 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🟋N If Yes, Give	lo	1 ☐ Yes 2 🔀 No		, 2227,	0/4	
5-0036	ture!	ed b	15. Decedent's Ed	Year or Dates:	16a.	Decedent's Usual Occur	pation		16b. Kind of Business/l	ack
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	then "ng	Completed	(Specify only highest gra	de completed) College (1-4 or 5	+)	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of working)	ng		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
J. W. 2	ygien ygien t, the		10th grade			Nursing	1		Hart Home	
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	ad oth	Be	17. Father's Name (First, Middle, Last) Linton		Rose		18. Mother's Name	(First, Middle, N		
aryla	mark mark	^C	19a. Informant's Name/Relationship (. Mailing Address (Street	Ella t and Number or Rura	l Route Number,	Rattley ; City or Town, State, Z	ip Code)
N N	Health ar tem 27 is tem 27 is		Ella M. Rose	Mother		901 Power 7	Dill:	ion, S.C	2953	6
\ / W -	of He of He or other		20a. Method of Disposition 1 12 Burial 2 Cremation 3		20b. Place of cemeter	901 Parry F Disposition (Name of y, crematory or other pla	ace)	ate	20c. Location - City or 1	own, State
altimor	tment tent: I jury o		*4 Donation 5 Other (Specification)	/)	Mt.	Zion Cem.	10-30		Lansdowne	
Balt	perimin. Tages I and a Stouce be used within Department of Health and Mental Hygiene. Importent: If item 27 is marked other then any injury or other treumatic svent. Item once.		21. Signature of Funeral Service Licer Blyman D	Ji moro		March F.H	•	Baltim 1101 E.	nore, Md. North Ave	21202
			23a. Part1. Enter the disease, or coord shock, or heart failure. List only	plications that caused one cause on each lin						Approximate Interval Between Onset and Death,
	hysician		Immediate Cause (Final disease or condition resulting in death)	a. Chror	nic 0	bshuct	tre Pul	mona	y Disea	se 5 y
	/Medical Examiner			Due to (or as a	a consequence	of):			0	•
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Box	attending	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy	3 Ectopic pregnanc	·v		23d. Date of delin	•
Records, P.O. Box	the att	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at 9□Unknown		5 Other (specify)			Month	Day Year
d	been signed by the should be detached		Part II. Other significant conditions of	ontributing to death bu	at not resulting in	the underlying cause gr	ven in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
rds	been sign	ed by	Obesity	K				1 □ Ye	es 2□No 3X Pro	bably 4 Unknown
e co	as be	Completed	Congesti.	ve He	a~t	Failure	2	24a. Was ar	v prior to c	opsy findings available
A B	certificate has rector, page 2	Con	Diabete	e Me	litus	>		perform 1 ☐ Yes 2	ned? death? 2 No 1 ☐ Yes	2□ No
Vita	ysicien: is certific director.	Ве	25. Was case referred to medical examiner?	Hospital:	-5	Ott	26. Place of Death		,	
of	After this funeral di	n: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injur	v 28b. 1	Time of 28c. Inju	4 Nursing Hor		once 6 Other (Spec	ify)
ion	ath. or: Afte	atio	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation		/ Year) II		Yes 2 No			
Division of Vital Records,	or an abaylor of Atlanting Frigericent. Within 24 hours after death. To the Fuhrerel Directors After this certification of the properties of the propertie	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Inju- building, etc	iry - At home, fa c. (Specify)	rm, street, factory, office	2	28f. Location (Str City or Town	reet and Number or Rui n, State)	al Route Number,
	hours unerel		29a. Certifier 1 Certifying Ph	ysician: To the best of	of my knowledge	, death occurred at the ti	me, date and place, a	and due to the ca	ause(s) and manner as	stated.
9	within 24 h To the Fur	Aedicai	one)	niner: On the basis of and manner sta	examination and ted.	d/or investigation, in my				
	To witi	Σ	29b. Signature and title of certifier	001	2 A 1	29c. Licen:	se number	/LO 29	9d. Date signed (Month	Day, Year)
			30 Name and address of therson who	completed cause of de	eath (Item 23a)	(Type, Print)	10 769	70	JUI de	T 2004
	8		Sanjay P.SI	1000 110	0 80	M. Eut	law #4	07, B	salt M	D2/20/
	Sta Registr		31. Date filed (Month, (Pay, Year)) OCT 2 8	2004 Degiste	ir's Signature	B Apo	rest .			

			For State Registrar	State of Maryl	-	artment of F rtificate of		_	giene Reg. No?	31,271
	Dhuninis		1. Decedent's Name (First, Middle, Last)					2. Date of De	ath Day Year	3. Time of Death
	Physicia /Medic		Dorothy Witm		3			October		1:30 P M
	Examin	er	4a. Facility Name (If not institution, give st. Keswick Multi Care			4b. City, Town, o		eath	4c. County of De	ath
			5. Social Security Number 6. Sex		yrs. last birthday)		imore	Irs. 8. Date of Birt	th 9. Bi	intholace (State or Foreign
	Funeral Director			M 2√F 88	Yrs.	Months Days	Hours N	lin. (Month, Da $Julv 07$	y, Year) C	irthplace (State or Foreign Country) Cyland
	D		Usual Residence of Decedent							·
	arylar	_	10a. State 10b. County	100	. City, Town or L	ocation				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	he M.	Director	MD	Ba	altimore	10f. Zip Code			10g. Citizen of What C	X
	with t		700 West 40th Str	eet		212	011		United St	•
	ns 23	Funerai		2. Was Decedent Ever	in U.S. 13.			' (Specify Yes or No Jerto Rican, etc.)		nerican Indian,
9	after or Ita		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give		If Yes, specify Cub 1 ☐ Yes X☐ No	an, Mexican, Pt Specify:	Jerto Hican, etc.)		
93	iral',	d by	3 XWidowed 4 ☐ Divorced	Year or Dates:		10 163 AC 110	эрвену.		Specify: Wh	
Maryland 21215-0036	within 72 hours after death with the Maryland ene. than "natural", or itams 23a or 28a-f show the Medical Examinational by motified at	Completed	15. Decedent's Educa (Specify only highest grade		16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	oation during most of d)	working	16b. Kind of Busines	s/industry
12	withly ene. than	E C	Elementary/Secondary (0-12)	College (1-4or 5+)		unselor	_,		State of M	laryland
5	filed Hygi othar	Be C	17. Father's Name (First, Middle, Last)				18. Mother's I	Name (First, Middle,	Maiden Sumame)	· · · · · · · · · · · · · · · · · · ·
<u>a</u>	ould be Mental arkad o atic eva	ToB	Charles Arthur Wi	tmyer			Marie	Consuelo	Hood	
ar)	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or liams 23a or 28a-1 show aumatic event, the Medical Examination will be multipled at		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Maili	ing Address (Street	and Number or	Rural Route Numbe	er, City or Town, State,	Zip Code)
	1 and 2 Health lam 27 othar tra			nd Cousin)	2807 b. Place of Disp	Baublitz	Road,	Owings Mi	11s, Md. 2 20c. Location - City of	1117
ŏ	Pages 1 nent of H int: If itan	1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	movel from State	cemetery, cre	matory or other pla dge Cemet				
Baltimore,	permit. Page Department Important: If any injury or once.		* 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee			2. Name and Addre		_		, Md. 21208
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If itam 27 Is marked any injury or other traumatic en		1 2 10 K000.	or Mess						l Directors 21133-4784
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the						Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	Sende 1	20mons	lia Mar	Leine	a Jun	0.	Onset and Death
	/Medical		resulting in death)	Due to (or as a cor	sequence of):	7		1		1
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	be tis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dua to (or an aleor	sacuance of):					
	ate be executed hysician and the burial-transit	хап	that initiated events c. resulting in death) Last	Due to (or as a cor	nsequence of):					
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9	ifficate g phys as the	ledic								
Box	th cer endin r use	an/N	23b. Was decedent pregnant	ic. If yes, outcome of pro		⊒Ectopic pregnanc	v		23d. Date of d	
о. П	e dea he att	Physician/Med	in the past 12 months? 1 🗆 Yes 2 🗓 No	4☐ Pregnant at time 9☐ Unknown		Other (specify)	,		Month	Day Year
P. 0.	The law requires that the death certificate has been signed by the attending prage 2 should be detached for use as		9 ☐ Unknown Part II. Other significant conditions cont	ributing to death but no	t resulting in the I	inderlying cause div	ven in Part I	23e, Did to	obacco use controute	to the cause of death?
ds,	signe d be d	d by	Tarrit. Other signment contains con	moduling to dodn't but no	i roodiiing iir iito t	andonying baabb g		1 🗆 🗅		Probably 4 Unknown
Ö	w requir been si should	Completed						24a. Was	an 24h Wara	autopsy findings available
Bě	he lav s has ige 2	ш						autor	prior to death?	completion of cause of
ta	ilcian: Th certificate rector, pag		25. Was case referred to medical				26. Place of	1 ☐ Yes Death (Check only o		es 2 No
<u> </u>	ysicia is cer direct	To Be	examiner?	ospital:	2 ER/Outpatie	nt 3□ DOA Ott			dence 6 □Other (Sp	ecify)
0	ding Ph h. After thi funeral		27. Man er of Death 1 ■ Natural 5 □ Pending	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	of 28c. Inju Wo	ry at rk?	28d. Describe I	how injury occurred	
Sio	tandii eath. or: A the fu	catio	2 Accident investigation 3 Suicide 6 Could not be]Yes 2 □No	001 1 11 11 11	0	
Division of Vital Records,	l or Attano after death Diractor:	Certification:	4 Homicide determined	28e. Place of Injury - building, etc. (S)	At home, farm, st <i>pecify)</i>	reet, factory, office		City or Tox	Street and Number or F vn, State)	Rurai Route Number,
	Hospital 24 hours a Funeral I stely filled		29a. Certifier 1 Certifying Physi	ician: To the best of my	knowledge, dea	th occurred at the ti	me, date and pl	ace, and due to the	cause(s) and manner a	as stated.
	To tha Hospital or Attanding Physician: The within 24 hours after death. To tha Funeral Diractor: After this certificate ha completely filled in by the funeral director, page	edical		er: On the basis of examiner stated.						
	To tha within 2: To tha complet	Me	29b. Signature and title of certifier	an hu		29c. Licens			29d. Date signed (Mor	
			> /www.xa	NY		10	3043	2	VU 26,	, 2004
	,0		30. Name and address of person who cor	BME 6	701 N	Print) CH MUES	ST	BELTIMO	OU 26, and Mo	21204
	Sta Registi		31. Date filed (Month, Day, Year) 2004	32. Registrar's S	Agnature 6	Spark				

State of Maryland / Department of Health and Mental Hygien 34272 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October 26 Irene T. Radtka 2004 10:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel General Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days 1 □ M 2 🖺 F 89 168 12 8134 Director YES 1915 Pennsylvania Usual Residence of Decedent 10a State 10b Count 10c. City, Town or Location 10d. Inside City Limits 28a-1 show the Medical Examiner must be notified at 1 □ Yes 2X No Maryland Anne Arundel Annapolis Direct 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 84 Old Mill Bottom Road North 23a 21401 U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō Specify: White 1 ☐ Yes 2X No Specify: þ 3 ₩ Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 12 should be filed within 72 h and Mental Hygiene." 7 is marked other than "ni Social Security Elementary/Secondary (0-12) College (1-4or 5+) Supervisory 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 0 (not available) Tkatch (not available) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ages 1 and 2 sl nt of Health and :: If itam 27 is r 7439 Balto. Annapolis Blvd. Glen Burnie, MD 21061 Michael Demyan / Attorney 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Holy Cross Cemetery 10/30/2004 Baltimore, Maryland 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Lice 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part. Enter the disease of complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Dneumonia Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 5 days Obstructive Pulmonary Distase 5 squantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.O. F 1 Yes 2 No the 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ should be ongest 1 ☐ Yes 2 € No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 1 ☐ Yes 2 ☑ No Yes 2 No Division of Vital To the Hospitel or Attending Physician: 25. Was case referred to medical Be 26. Place of Death Check on one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No ٩ 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ determined hours after 4 Homicide within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10058237 October 26, 2004 Name and addr ss of person who completed cause of death (Item 23a) (Type, Print) Medical Center Annapolis, MD 21401 6 Anne Arundel 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 28 2004 Registra

Please Type or Print in Black Indelible Ink	c. Ensure All Copies Are Legible.
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1. Decedent's Name (First, Middle, Last) 2. Date of Death 2. Separation 3. Time of Death 12. Separation 3. Time of Death 12. Separation 1. Decedent's Name (First, Middle, Last) 1. Decedent's Name of Decedent 1. Decedent's Name			1- State of Maryland / Departme Registrar Certifica	nt of Health and Nate of Death	Mental Hygier		34273
Section of the Sect			Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	20.00
Total Part Tot			4a. Facility Name (If not institution, give street and number) 4b. Cit SINAI HOSPITAZ OF BALTIMORE BA	ATIMORE (city	tc. County of Deat	/A
Security Teach Too County Teach Too Count			□27-10-2802 1□XM 2□F 93 Yrs. Month		(Month, Day, Yea	9. Birt 1911 Mass	
1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Oher (Speechy) St. John 5 Cemetery 10/30/04 Worcester, MA 4 Donation 5 Oher (Speechy) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 21 204 Approximate interest leaves on each line. Approximate interest leaves of line Approximate interest leaves on each line. Approximate leaves leaves on	Maryland -f show	tor	10a. State 10b. County 10c. City, Town or Location	Mt Washington	n		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Oher (Speechy) St. John 5 Cemetery 10/30/04 Worcester, MA 4 Donation 5 Oher (Speechy) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 21 204 Approximate interest leaves on each line. Approximate interest leaves of line Approximate interest leaves on each line. Approximate leaves leaves on	sa or 28a	i Direc	10e. Street and Number 10f. 2	ip Code			untry?
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1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Oher (Speechy) St. John 5 Cemetery 10/30/04 Worcester, MA 4 Donation 5 Oher (Speechy) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 21 204 Approximate interest leaves on each line. Approximate interest leaves of line Approximate interest leaves on each line. Approximate leaves leaves on	t be filed v ntal Hygie ad other t	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam	ne (First, Middle, Maide	en Sumame)	
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22a. Date of delivery Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Was case referred to medical conditions contributing to death but not resulting in the underlying cause given in Part I. 23c. If yas, outcome of pregnancy in the past 12 months? In Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23c. If yas, outcome of pregnancy in the past 12 months? In Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23c. If yas, outcome of pregnancy in the past 12 months? In Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23c. If yas, outcome of pregnancy in the past 12 months? In Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23c. If yas, outcome of pregnancy in the past 12 months? In Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23c. If yas, outcome of pregnancy in the past 12 months? In Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23c. If yas, outcome of pregnancy in the past 12 months? In Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23c. If yas, outcome of pregnancy in the past 12 months? In Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23c. If yas, outcome of pregnancy in the past 12 months? In Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23c. If yas, outcome of pregnancy in the past 12 months? In Part II. Other significant conditions contributing to death but not resulting in the underlying	ages 1 an int of Heal t: If item 2 y or other		20a. Method of Disposition 1 🗵 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (A cemetery, crematory of	ame of rother place)	Date 20c.	Location - City or	Town, State
23a Part Enter the disease, or consistants that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inches chreat failure. List of your cause on each line.	permit. P Departme Importan any injur		21. Signature of Funeral Service Licensee 22. Name	and Address of Facility Ruo	ck Towson f	Tuneral H	Home, Inc.
Due to (or as a consequence of): Due to (or as a consequence of):	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	ode of dying, such as cardiac	or respiratory arrest,		Interval Between Onset and Death
FFEMALE: 230. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 23d. Date of delivery Month Day Year 25c. Month Day D	ite be nysicia ne bur	icai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
	the death certifies y the attending phone ched for use as t		23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic				
	quires mat n signed b uld be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying	g cause given in Part I.			
	The law rerate has bee page 2 sho	Complete			autopsy performed?	prior to death?	completion of cause of
	nding Physician ith. : After this certifi s funeral director	To B	examiner? 1	Other: 4 Nursing Ho 28c. Injury at Work?	ome 5 Residence		sify)
	tal or Attants after destal Diractored in by the	Certifica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fact	ory, office			ral Route Number,
	the Hospi hin 24 hour tha Funera npletely filk	edicai	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	on, in my opinion, death occur	rred at the time, date a	ind place, and due	to the cause(s)
The state and address of person who completes equal of usual fillen 230 (1908, Fills) U.A. 14 1// L. 1// U.A. 1	To To To Con	2	M.D.	RES - 000			
TI DR MORKISON - BRYANT MD SINH HOSPITAL OF BALTIMORE. State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature Sports Sports	41 Sta	to.	DR MORKISON-BRYANT MD STE		AL OF	BALTIM	ORE.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen n.

		-	For State Registrar	state of Maryland / E	Certificate of Death	Reg. N	
	Physicia	ın	Decedent's Name (First, Middle, Last)	0.		2. Date of Death	3. Time of Death
	/Medic Examin	al -	4a. Facility Name (If not institution, give str	Shawqi eet and number)	4b. City, Town, or Location of Death	veraner 8	12,3004 8,35/7 c. County of Death
			Mercy Hospite	1	Baltimora hdav) If Under 1 Year If Under 24 Hrs.	0. D-1(B)+	N/A
	Funeral Director		214-68-2891	7. Age (In yrs. last birt	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	ar) 9. Birthplace (State or Foreign Country) MD
	yland now		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	n or Location		10d. Inside City Limits
	Be-f st	ctor	MD N/A	Balti	more		1 ØYes 2 □ No
	with th	Dire	10e. Street and Number 6600 Eberle	Dr. = 301	10f. Zip Code		Citizen of What Country?
	ems 2	Inera	11. Marital Status	. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert		14. Race - American Indian, Black, White, etc.
920	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. It health and Mental Hygiene. It marked other than "neturel", or items 23e or 28e-f show other treumetic event, the Marchael Examination ust be multified at	by Funeral Director	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 PNo If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: Black
215-0036	n 72 ho "netu	letec	15. Decedent's Educa (Specify only highest grade	completed)	Decedent's Usual Occupation (Give kind of work done during most of wor life. DO NOT use retired)	king 16b.	Kind of Business/Industry
212	should be filed within nd Mental Hygiene. marked other then imetic event, Ille M.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	aintenance	5	elfemployed
	l be file ntal Hy ad oth	Be	17. Father's Name (First, Middle, Last)			ne (First, Middie, Maide	en Sumame) ()
Maryland	2 should I and Mani is marke	2	Frank H. Li 19a. Informant's Name/Relationship (Type	evers 9. Print) 19b.	Mailing Address (Street and Number or Ru	ral Route Number, City	or Town, State, Zip Code)
	1 and 2 Health a em 27 is		Marion Baks	1 Mother 64	000 Eberle Dr. &	30 \ 3cito	MD 21215
nore	ages 1 int of H t: If ite y or otl		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	moval from State cemeter	Disposition (Name of y, crematory or other place)		Location - City or Town, State
Baltimore,	permit. Pages 1 and Department of Health Importent: If Item 27 eny injury or other tr once.		21. Signature of Funeral Service Licensee		22. Name and Address of Facility	swell Fur	
8	9 E 9 G		1/2run / 9	twells	14600 in her Hy Hei	ghts Ave	Balte, MD 21207
			Immediate Cause (Final				Approximate Interval Between Onset and Death
7	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence	to collular Carcin	0.00	
	Examiner	-	Sequentially list conditions, b.	Due to (or as a consequence	tutes B+C		
×	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	bus to for as a consequence t	vi)-		
, 06	rificate be executed ng physician and as the burial-transit		resulting in death) Last	Due to (or as a consequence	of):		
68760,	ficate by physical for the b	Medical	d.				
Вох			IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death			23d. Date of delivery Month Day Year
Ö	the deay y the a	Physician/	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time of death 9□Unknown	5 Other (specify)		,
s, p	law requires that the death ce as been signed by the attendii 2 should be detached for use	by PI	Part II. Other significant conditions control	1	the underlying cause given in Part I.	_	o use contribute to the cause of death?
cord	v requi	eted	To Cystat Imm	modeficiens	>>> 600-4	1 ☐ Yes	
of Vital Records,	The lay ate has page 2	Completed by				autopsy performed?	
/ital	Physicien: rthis certifica ral director, p	Be	25. Was case referred to medical examiner?	spital:		ath (Check only one)	
of	g Physical this coral dir	n; To	27. Manner of Death	28a. Date of Injury 28b. 1	Time of 28c. Injury at	ome 5 Residence 28d. Describe how in	
sion	Attending r death. ector: After by the funer	catlo	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	njury Work? M 1 ☐ Yes 2 ☐ No		
Division	after de Direct	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
				cian: To the best of my knowledge	, death occurred at the time, date and place	, and due to the cause	(s) and manner as stated.
	e Hospite 24 hours e Funerel etely fille		29a. Certifier Certifying Physi (Check only one) 2 Medicel Examine	er: On the basis of examination an and manner stated.	d/or investigation, in my opinion, death occu	rred at the time, date a	and place, and due to the cause(s)
_	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medical ((Check only 2 Medical Examina	er: On the basis of examination an and manner stated.	d/or investigation, in my opinion, death occu		Date signed (Month, Day, Year)
•	0.	edical	(Check only 2 Medicel Examination) 29b. Signature and title of certifier	ar: On the basis of examination an and manner stated.	d/or investigation, in my opinion, death occur 29c. License number D40854		
)	To the Hospite within 24 hours To the Funerel completely filler	edical	(Check only one) 2 ☐ Medicel Examina 29b. Signature and title of certifier 30. Name and address of person who con	ar: On the basis of examination an and manner stated.	d/or investigation, in my opinion, death occur 29c. License number D40854		Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

	•	For State of Mar	yland / De _l <i>C</i> e	partment of Fertificate of I	lealth and N Death	Лental Нус г	gien 2 0 0 4	34275
Dhygiaio		Decedent's Name (First, Middle, Last)				2. Date of Dea		3. Time of Death
Physicia: /Medica		Vesta Moyer	r Sharp			October		5:55 A M
Examine	r	ta. Facility Name (If not institution, give street and number)	100		Location of Death		4c. County of Death	
Formul		Montgomery Hospice Casey Hot 5. Social Security Number 6. Sex 7. Age (ise In yrs. last birthda	Rockvi		8. Date of Birth	Montgom	ery Dlace (State or Foreign
Funeral Director		207-18-8508 1□M 2\\ F 78	Yrs.	Months Days	Hours Min.	(Month, Day February	v. Year) Cour	sylvania
p ,		Usual Residence of Decedent	0c. City, Town or					
shov	5							0d. Inside City Limits 1 X Yes 2 No
the N	Director	Maryland Montgomery 10e. Street and Number	Rockvi	10f. Zip Code			10g. Citizen of What Cour	
death with the Maryland rms 23a or 28a-f show rmust be rotified at	2	2102 McAuliffe Drive		20851			United State	Salar I
death	Funeral	11. Marital Status 12. Was Decedent Eve Armed Forces?	er in U.S.	3. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp	pecify Yes or No-	14. Race - Americ Black, White,	
s after	by Fu	1 Never Married 2 Married 1 Yes 2 No	1	1 ☐ Yes 2 No	Specify:	Tiloan, sto.)	Specify: White,	
"natural, or		3 ☑ Widowed 4 □ Divorced Year or Dates:	16a Dec	cedent's Usual Occup	ation		16b. Kind of Business/In	
n "na	blet	(Specify only highest grade completed)	(Gi	ve kind of work done on DO NOT use retired	during most of work	king	TOD. KING OF BUSINESS/III	oustry
Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Staf	f-Church P	ublicatio	ons	Cathedral	
land Id be file ental Hy ked oth	Re	17. Father's Name (First, Middle, Last)					Maiden Sumame)	
ABIVIANG ZIZIO-UUSO 2 should be filed within 72 hours after death with the Marylan 1 and Mental Hygiene. Is marked other than "natural, or Items 23a or 28a-1 show raumatic avant, the Medical Exam incrinitative colline at	0	Frederick Moyer	405 14-	· · · · · · · · · · · · · · · · · · ·		tta Gask		
	И	19a. Informant's Name/Relationship (Type, Print) Teresa Black/Friend		-			r, City or Town, State, Zip Maryland 21	· ·
Gore, Maryla ges 1 and 2 should t of Heath and Mer t it itam 27 is marke or other traumetic	-	20a. Method of Disposition	20b. Place of Dis	position (Name of		Date	20c. Location - City or To	
Pages bent of nrt: If i		1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify)		rematory or other place 7 Crematorium		ber 28	Bethesda, Ma	aryland
Baltimore, permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once.		21. Signature of Funeral Service Licensee	R	22. Name and Addres	ss of Facility Threy Fune	eral Home/	Rockville, Inc	2, 20950, 2905
		23a. Part1. Enter the disease, or complications that caused th						Approximate Interval Between
Proysician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Lung	Cancer					Onset and Death Ionths
/Medical		resulting in death) a Due to (or as a co						
Examiner		Sequentially list conditions, b.						
led is	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (1888) of the property of that initiated ovents c.	consequence of):				84	
execunand and al-tran	xan	that initiated events c	consequence of):					
	dicail	d						
rtifical ng phr as th	Medi	IF FEMALE:						
death certific	Pnysician/Me	23b. Was decedent pregnant 23c. if yes, outcome of	Fetal death	3 □Ectopic pregnancy			23d. Date of delive Month	ery Day Year
he de 'the a	ysic	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 1 □ Yes 2 ☑ No 9 □ Unknown	ne of death 5	5 🗋 Other (specify)				24,
w requires that the deben signed by the	7	Part II. Other significant conditions contributing to death but r	not resulting in the	underlying cause give	en in Part I.	23e. Did to	bacco use contribute to the	ne cause of death?
Hecords,	og po					1 🔯 Y	es 2□No 3□Prob	ably 4 Unknown
aw reads to shoot 2 shoot 2	plet					24a. Was a		psy findings available
The I	Completed					autop: perfor	med? death? 2 No 1 Yes	mpletion of cause of 2 No
VICAL THE SAN SICIAN: The SAN SCHLISCOT, PAGE 2 SI SIRECTOR, PAGE 2 SI	ge	25. Was case referred to medical examiner?			26. Place of Deat	h (Check only or	ne)	
Physic rthis c	0	1 ☐ Yes 2 🛣 No Hospital: 1 ☐ Inpatient					ence 6 Other (Specific	y)Hospice
ding the After funer	lon	1 X Natural 5 ☐ Pending (Month, Day Y	ea <i>r)</i> 28b. Time Injun	/ Worl	/at <br Yes 2 □ No	28d. Describe n	ow injury occurred	
lor Attanding after death. Diractor: After in by the fune	ertification;	3 Suicide 6 Could not be 28e. Place of Injury	- At home, farm,	street, factory, office		28f. Location (S	treet and Number or Rura	I Route Number,
s after al Dire	2 L	4 Homicide determined building, etc. (Specify)			City or Tow	n, State)	
	Medical	29a. Certifier 1\(\begin{align*}{\text{L}}\) Certifying Physician: To the best of response one) (Check only one) (2 \(\begin{align*}{\text{Medicel Examiner:}}\) Medicel Examiner: On the basis of evaluation and manner states	camination and/or	ath occurred at the tin investigation, in my o	ne, date and place, pinion, death occur	and due to the c red at the time, d	cause(s) and manner as si date and place, and due to	tated. the cause(s)
To th To th comp	ME	29b. Signature and title of certifier		29c. License	e number	2	29d. Date signed (Month,	Day, Year)
		Chilippine		BR42	16114		October 25,	2004
15		30. Name and address of person who completed cause of deal Chitra Rajagopal, M.D. 6001		·	oad, Rock	ville,	Maryland 208	355
Stat Registra	- 3	31. Date filed (Month, Day, Year) OCT 2 8 2004 32. Registrar's		par spar	2			

		1 - For State Registrar	State	of Marylar	nd / Depa <i>Cei</i>	artment of F	lealth Death	and Mei	ntal Hyg	ene 0 ()4	34276
	7	1. Decedent's Name (First, Middle, La	st)					2.	Date of Deat	1		3. Time of Death
Physic /Med		Bonnie Deen Sha	W					0	ctober	25, 20	004	12:20 P M
Exam		4a. Facility Name (If not institution, giv	e street and nu	mber)		4b. City, Town, o	r Location	of Death		4c. County	of Death	1
		Montgomery Hosp				Rockvi				Mont		
Funera		5. Social Security Number 6. S	ex □M 2⊠F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	Date of Birth (Month, Day,	Year)		place (State or Foreign untry)
Directo	r	476-12-4320 Usual Residence of Decedent		64				0	ctober 1	9,1920	Sout	th Dakota
/land		10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation						10d. Inside City Limits
Many a-f eh	tor	Maryland Montgom	erv	Ro	ckvill	e						1⊠Yes 2☐No
h the	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of	What Col	untry?
23£ (23£ (23£ (23£ (23£ (23£ (23£ (23£ (2453 McCormick Ro	ad			20850			ַ	nited	Stat	es
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Maxiles Examinat must be notified at	Funeral	11. Marital Status	Armed F		.S. 13.	Was Decedent of H If Yes, specify Cubi	lispanic Or an, Mexica	rigin? (Specifi an, Puerto Ric	y Yes or No- an, etc.)		ce - Amer ck, White	ican Indian, , etc.
S afte	by Fi	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 □Yes If Yes, G Year or [2 ₩ No ive		1 ☐ Yes 2 🛣 No	Specify	<i>/</i> :		Specif	y: 1.71-	nite
hour		15. Decedent's E		74105.	16a. Dece	dent's Usual Occup	ation		1 1	6b. Kind of B		
nin 72	Completed	(Specify only highest gr. Elementary/Secondary (0-12)	ade completed)	-	(Give	kind of work done DO NOT use retire	durina mos	st of working				,
d with	Eo	12	College (1-4or 5+)	Hom	emaker				Own H	lome	
al Hyginothe	Be	17. Father's Name (First, Middle, Last)				18. Moth	ner's Name (F	irst, Middle, M	laiden Sumar	ne)	
Ments Ments arked	10	Fred Behrens					Edi	na 0 ' D	e11			
and and Is my		19a. Informant's Name/Relationship (**			ng Address (Street						
and and lealth m 27		Harry Shaw/ Hus	band	205		McCormick	Road,					
ges 1 t of H if ite		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from		cemetery, crei	sition (Name of matory or other place 1 auro	ce)	Octob	er	Oc. Location	- City or I	own, State
t. Pa rtmen rtant:		' 4 □ Donation 5 □ Other (Special		Me	Párk morial	-Pärk		28, 20	004 F	Rockvil	.le,	Maryland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28a-1 ehow any injury or other traumatic event, in a Madical Examiner must be notified at	SIICE	21. Signature of Fineral Service Lice	3	M014	05 R	ockville,	Inc	. 300 j	10850 Mc	ntgome	ry A	neral Home/ venue
		23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that one cause on	caused the deat	th. Do not ent	er the mode of dying	ng, such as	s cardiac or re	espiratory arre	st,		Approximate Interval Between
Physician	1	Immediate Cause (Final disease or condition	a	Ca	rcinom	a Unknown	Prin	mary			_ 1	Onset and Death Months
/Medica Examine	_	resulting in death)	Due to	(or as a consec	quence of):			•				
LAGITIME		Sequentially list conditions,	b. — Due to	(or as a consec	wones of							
lsit 66.7	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10	(or as a consec	puerice or).							
cate be executed physician and the burial-transit	xar	that initiated events resulting in death) Last	cDue to	(or as a consec	(uence of):							
sicial s buri	dical		d									
g phy as th	(a)											
The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant		itcome of pregnation		Ectopic pregnancy	,			1	te of deliv	,
deal deal	sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No		nant at time of o		Other (specify)				Mo	onth	Day Year
at the	Phy	9 Unknown							an- Dida-b		- 16 A A	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
uires that the density signed by the a	by	Part II. Other significant conditions	contributing to c	leath but not res	sulting in the u	nderlying cause giv	en in Part	1.				the cause of death?
w requir been si should	Completed		-						•			
e law has b	nple								24a. Was an autopsy perform	24b.	Were aut prior to co death?	opsy findings available ompletion of cause of
The The Icate										₩ No	1 Yes	2 🗆 No
sician: The law scertificate has t	Be	25. Was case referred to medical examiner?	Hospital:			at all pos Oth			heck only one			
or Attanding Physician: The viter death. Director: After this certificate him by the funeral director, page	5.	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 1	·	28b. Time o	IL SEL DOX	4 🗆 141		5 Resider			Hospice
ding Ith.: After	tlon:	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation		of Injury oth, Day Year)	Injury	f 28c. Injur Wor M 1 🗆	k? Yes 2 ⊑]No				
or Attendate death Director:	fica	3 ☐ Suicide 6 ☐ Could not b	200. Flac	e of Injury - At h	ome, farm, str	reet, factory, office		28f.			er or Rui	al Route Number,
al or safte	Certificat	4 Homicide	Dulic	ling, etc. (Speci	(y)				City or Town,	State)		
To the Hospital or Attending Physician: within 24 hours after death. To the Suneral Director: After this certifica completely filled in by the funeral director.	Medical C	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa-	miner: On the b	e best of my kno casis of examina nner stated.	owledge, deat ation and/or in	h occurred at the tir vestigation, in my c	ne, date ar pinion, dea	nd place, and ath occurred	I due to the ca at the time, da	use(s) and ma te and place,	anner as a	stated. to the cause(s)
To the vithin To the comple	ĭ ⊠	29b. Signature and title of certifier				29c. Licens	e number		29	d. Date signe	d (Month,	, Day, Year)
F > F 0		> Chihi y	he			BR42	16114	, +	0.	ctober	25	2004
		30. Name and address of person who	completed cau	ise of death (Iter	n 23a) (Type,				3,	LUDGE	,	
15	Y	Chitra Rajagopal	M.D.,	6001 Mt	uncaste	er Mill R	oad,	Rockvi	11e, M	arylan	d 20	855
	State	31. Date filed (Month, Day, Year)	32.1	Registrar's Signa						,		
Regis	strar	OCT 2 8 201	71 1	ensava	4	/						

ORIGINAL

			1- State of Maryland / Dep	partment of Health and Mertificate of Death	lental Hygien	2004 34277
	Physicia		Decedent's Name (First, Middle, Last) ROBERT THOMAS STREETS		2. Date of Death Month Da	ay Year 3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death
	Funeral		WASHINGTON COUNTY HOSPITAL 5. Social Security Number 6. Sex, 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Year	WASHINGTON 9. Birthplace (State or Foreign
	Director		234-64-3241 1	Months Days Hours Min.	6/7/1941	WEST VIRGINIA
	/anyland show	or	10a. State 10b. County 10c. City, Town or	Location ARTINSBURG		10d. Inside City Limits 1 ☐ Yes 2 No
	with the h e or 28a-i	Direct	10e. Street and Number 71 PICTURE MOUNTAIN DRIVE	10f. Zip Code 25401	10g. C	Litizen of What Country?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23e or 28e-f show any njury or other treumetic event. If e Modical Examiner must be multiped at once.	by Funeral Director		3. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE
21215-0036	within 72 hou ane. then "nature	Completed	15. Decedent's Education 16a. De (Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of work DO NOT use retired) MACHINIST		Kind of Business/Industry MACK TRUCKS
land 2	ld be filed ental Hygi ked other ic event.	To Be Co	17. Father's Name (First, Middle, Last) WILLIAM STREETS		e (First, Middle, Maide RUDE HOOPEN	/
Maryland	nd 2 shou alth and M 27 Is mar ir treumet	-		illing Address (Street and Number or Run ICTURE MOUNTAIN DRIVE,		
Baltimore,	Pages 1 a nent of Hei int: If item iry or othe		1XXBurial 2 □ Cremation 3 □ Removal from State	position (Name of rematory or other place) OWN PRESB. CEM. 20, 2	R GF	Location - City or Town, State RRARDSTOWN, WV
Balti	permit. Departn Imports any nju		21. Signature of Funeral Service Licensee	22, Name and Address of Facility P. BROWN FUNERAL HOME P. MARTINSBURG,	O. BOX 821, 3 WV 25402	327 W. KING ST.,
	Physician /Medical Examiner	er	23a. Part. Enter the disease, or complications that ceused the death. Do not eshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
8760,	ficate be executed physician and s the burial-transit	dicai Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): d		_	
.O. Box 6	death certii e attending id for use a	Physician/Me		B□Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
rds, P	Se co	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco 1 ☐ Yes 2	ouse contribute to the cause of death? 2 🗆 No 3 🗀 Probably 4 🖅 Onknown
al Records,	The ate h page	Completed			24a. Was an autopsy performed? 1 Yes 2 N	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
Vital	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Matient 2 ER/Outpat	Othor	h (Check only one) me 5 Aesidence	6 □Other (Specify)
on of	fter	ion: T	27. Manner of Death 1 Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at	28d. Describe how inju	
Division	l or Attending after death. Director: After I in by the fune	ertification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		28f. Location (Street a City or Town, Stat	and Number or Rural Route Number, te)
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical C	29a. Certifier Cartifying Physician: To the best of my knowledge, de (Check only one) Cartifying Physician: To the best of my knowledge, de (Check only one) and manner stated.			
)	To th withir To th	Me	29b. Signature and title of codifier	29c. License number	3 18	ate signed (Month, Day, Year)
	8		30. Name and address of person who completed cause of death (Item 23a) (Typ. Ne. 1 0 Malley MD 1150 Posts.	e, Print) C+ Suite C	Hespetal	n. MD 21740
	Sta Registi		31. Date filed (Month, Day, Year) OCT 2 8 2004 32. Registrar's Signature	Apolle	,	1
				V		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 6:15 A.M. Charles E. Shears, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cumberland
If Under 1 Year | If Under 24 Hrs. MEART SHCred 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1**X**M 2□F Yrs 75 **Director** 233-44-5195 June 3, 1929 West Virginia Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits other then "natural", or items 23s or 28s-f showers, the Medical Examiner must be notified at 1 Yes 2 No WV Mineral Keyser Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 231 Mozelle Street USA filed within 72 hours after death 1 Hygiene. 26726 Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify by Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Brakeman & Fireman Railroad permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: if item 27 is marked oths any injury or other treumetic event, 9069. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Owen Shears Lucy Cavanaugh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Della Deloris Shears/ Wife 231 Mozelle Street Keyser, WV 26726 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Oct. 26 ' 4 ☐ Donation 5 ☐ Other (Specify) Queen's Point Cemetery 2004 Keyser, WV 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Smith Funeral Home Busin Keyser, WV 1 85 S. Main Street 26726 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** pheumonia /Medical Due to (or as a consequence of) Examiner YwKJ. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): physician ar Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4 Pregnant at time of death 5 Other (specify) ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ directe 3€Probably 4 □Unknown 1 TYes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate ha 1 Yes 1 Yes 257 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No Wursing Home 5 Residence 6 Other (Specify) Inpatient Certification: To 2 FR/Outpatient 3 DOA 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 Aatural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 2 Mo 29d. Date signed (Month, Day, Yea critical HOUS 3855 care 30. Name and address of person who completed cause of death (Item 23a) (Type. Print) Scienced Heart Hospital Stanley J. Matyasik, D.O. 500 Jeton Dr. We, Comberla. Metya, 1/2, 0.0. 31. Date filed (Month, Day, Year)
OCT 2 8 2004 State Registrar

				For State Registrar	State o	f Man	yland / Dep <i>Ce</i>	artment of H	lealth and N Death	Mental Hyg	iene 0	04	3427	9
		Physici	an	1. Decedent's Name (First, Middle	-					2. Date of Dear Month	th Day	Year	3. Time of Death	
		/Medic	cal	Harry E. Schop				45 Oits Town	Landing of Donah	October	_	004	6:20 A	м
		Examin	ier	4a. Fecility Name (If not institution Suburban Hospi	77	mber)		Bethes	Location of Death			ity of Death Gomer	,	
		Funeral		Social Security Number		7. Age (I	n yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birthp	lace (State or Forei	gn
		Director		220-12-5197	6. Sex 1 2 M 2 ☐ F	87	Yrs.	Months Days	Hours Min.	(Month, Day, 07/12/1	917	MD Couit	ntry)	
		pur *		Usual Residence of Decedent 10a. State 10b. County		10	0c. City, Town or Lo	ncation				1	0d. Inside City Limi	ts
		darylan f show	ō		~~~~								1 □ Yes 2X N	
		the Mire	rect	MD Monto	gomery		Potoma	10f. Zip Code		1	0g. Citizen o	f What Cour	ntry?	
		23e or	a D	7301 Loch Edin	Court			20854		Į	United	State	es	
		ema ema	iner	11. Marital Status	12. Was Dec	orces?	er in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	pecify Yes or No-		ace - Americ		
	36	ours after death with the Maryla ral', or Itema 23e or 28e-1 shov Examinat must be notified at	y F.	1 ☐ Never Married 2X Marri 3 ☐ Widowed 4 ☐ Divorced	If Yes Gi	ve		1☐Yes 2☒No	Specify:		Spec			
	9	filed within 72 hours after death with the Maryland Hyglene. uther than "natural", or Itema 23e or 28e-f show ther than "natural pe molified at ent, the Medical Examinar must be molified at	Completed by Funeral Director	15. Deceden		ates:	16a. Dece	dent's Usual Occup	ation		16b. Kind of	Business/In	dustry	
	215	f within 72 ho liene. r than *natur the Medical	plet	(Specify only higher Elementary/Secondary (0-12)	st grade completed) College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of world ()	king			,	
	21	e filed withing Hygiene. other than vent, the M	Con	12			Assoc	iate Dire					Service	
	Maryland 21215-0036	be file	To Be	17. Father's Name (First, Middle,						e (First, Middle, I	Maiden Suma	ame)		
	ryla	2 should be to and Mental by and Mental bis marked of raumatic ever	To	Hiram Schoppe: 19a. Informant's Name/Relations			19h Maili	ing Address (Street		Splain	City or Tow	n State 7in	Codel	
		s 1 and 2 should be filed f Health and Mental Hyg item 27 is marked othel other traumatic event,		Lucille S. Scho		Fo		N & 2553					Oddoy	
	ē,	s 1 and 2 of Health item 27 l		20a. Method of Disposition]:	20b. Place of Dispo	Loch Edition (Name of matory or other place	e)	Date	20c. Location	20854 - City or To	wn, State	
	mo	Pages nent of h unt: If its ury or o		1 Burial 2 ☐ Cremation 4 ☐ Cremation 5 ☐ Other (S		State :		Valley Me		9/2004	rimoni	um, MI		
	3altimore,	permit. Pages Department of I Important: If it eny Injury or of		21. Signature of Funeral Service	Licensee	4		2. Name and Addres						Ιn
		205 g		MAN	moun	10		112 Old C				ıty, M		
				23a. Part1. Enter the disease, or shock, or heart failure. List	only one cause on	each line.		-	g, such as cardiac	or respiratory arre	est,		Approximate Interval Between Onset and Death	
		Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a		y Embolus	5						
-	н	Examiner			Due to	(or as a c	onsequence of):							
ε,		194	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	(or as a c	onsequence of):							
SOAM	(cuted	Examiner	that initiated events	c					-				
30	90,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to	(or as a c	onsequence of):							
9	8760,	ate the	dica		d									
	9 x	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome of p	pregnancy				23d. D	ate of delive	erv	
7	Box	death e atter d for u	Iclar	in the past 12 months?	4☐Preg	nant at tim		⊒Ectopic pregnancy ⊒ Other <i>(specify)</i>		-		lonth	Day Year	
9	P.O.	that the de ed by the detached	hys	9 Unknown	9□ Unkn	own								
10-26-04		res tha signed be det	by F	Part II. Other significant condition Congestive He	_		not resulting in the u	inderlying cause give	en in Part I.				e cause of death?	
	ord	w requir been si should	eted			пе					T		ably 4 X Unknow	
	Records,	e law has b	Completed by	Renal Insuffi	LClency					24a. Was as autops perform	y	. Were auto prior to col death?	psy findings availab npletion of cause of	le
_	a		e Co	25. Was case referred to medica					00 Di (D	1 ☐ Yes 2	X No	1 🗌 Yes	2□ No	
PE	of Vital		To Be	examiner? 1 Yes 2X No	Hospital:	npatient	2 ER/Outpatie	nt 3 DOA Oth	26. Place of Deat er: 4 ☐ Nursing Ho	th <i>(Check only on</i>		ther (Specifi	()	
101		ding Phys h. After this funeral di	T:u	27. Manner of Death	28a. Date					28d. Describe ho			,	
S.	Sior	endin sath. or: Af he fur	atlc	1 X Natural 5 ☐ Pendir 2 ☐ Accident investi	gation		,		Yes 2 □ No					
7	Division	frer de lirect	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be nined 28e. Place build	of Injury ing, etc. (At home, farm, st Specify) 	reet, factory, office		28f. Location (St. City or Town	reet and Num , State)	ber or Rura	l Route Number,	
HARRY SCHOPPE		pital ours a eral C		29a. Certifier 12 Certifyir	ng Physician: To the	a best of n	ny knowledge, deat	th occurred at the time	o date and place	and due to the co	uso(e) and n	nannor as s	ated	
E		24 hc 24 hc Fun etely	edical	(Check only 2 Medical one)	Examiner: On the b	asis of ex	amination and/or in	ivestigation, in my o	pinion, death occur	red at the time, da	ate and place	, and due to	the cause(s)	
		To the Hospital or Attending PI within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Me	29b. Signature and title certific	r			29c. Licenso	number	25	9d. Date sign	ed (Month,	Day, Year)	
		. 7		Mal				BR87	77495		10/26/	2004		
		10		30. Name and address of person										
				Rohatgi Atul 31. Date filed (Month, Day, Year)	8600 Old	*	getown Ro	pad Be	ethesda,	MD 2081	.4			
		Sta Registr		The sale med (Month, Bay, 18a)			of Local	E)						

DHMH 17 Rev 1/2001

HARRY SCHOPPET

			State of Maryland / De State of Maryland / De RegistrarAMEND ITEM #19b PER INF C836	partment of Health and M artificate of Peath		eg. No. UU4	34280
	Physici		Sylvia S. Saun	ders	Month	Day Year 2004	10:17 AM
)	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	
			Good Samaritan	Balto Balto Balto Balto		N/A	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Manager Davis Harris Adi	8. Date of Birth (Month, Day, 8 21	1939 9. Bir	hplace (State or Foreign buntry) N • C
			Usual Residence of Decedent		0 21	1939	
	show	7	10a. State 10b. County 10c. City, Town of				10d. Inside City Limits 1 XYes 2 □ No
	the M	Director	Md N/A Balto	10f. Zip Code	10	ng. Citizen of What Co	
	h with		1405 Kitmore Road	21239		USA	
	ems 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
36	ours after death with the Marylan ral', or Items 23e or 28e-f show Examiner must be notified at	ьу F.	1 □ Never Married 2 □ Married 1 □ Yes 2 No If Yes, Give 3 □ Widowed 4 ☑ Divorced Year or Dates:	1 ☐ Yes 2 XNo Specify:		Specify:	Black
21215-0036	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show seleal Examirer must be notified at	ted I	15. Decedent's Education 16a. D	cedent's Usual Occupation	1	16b. Kind of Business	Industry
215	E . E .	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ive kind of work done during most of working. DO NOT use retired)	ng N	Morgan Sta	te University
12	77 00 10		12th grade College Masters Pi	ofessor of English 18. Mother's Name	(First Middle N	faiden Sumame)	
Maryland	be d all all all all all all all all all a	To Be	James W. Sifford	Julia F		and of real name,	
ary	and and sm	1-	19a. Informant's Name/Relationship (Type, Print) 19b. N	ailing Address (Street and Number or Rura	l Route Number,	City or Town, State,	Zip Code)
ĕ,	an Ball n 2		Brenda S. McClary - Sister 6527	PAWNEE Pawner Drive Charl Sposition (Name of D			T
יסר	of of		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	crematory or other place)		20c. Location - City or Catonsvill	
Baltimore,	permit. Page Department Important: Il any injury o	i	'4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	22 Name and Address of Facility			z, na
B	pen pen pen pen pen pen pen pen pen pen		Finitte B. Jones	Ma 4300 Wabash Avenu	rch F/H	West . Md 21215	
	a		23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac o	r respiratory arre	est,	Approximate Interval Between Onset and Death
8760,	/Medical by sician and busician and busician and busician and street streets the burial-transit	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of) Due to (or as a consequence of)	CINDMA) L	UNGS		4 MONTHS
.O. Box 6	death certifi e attending id for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of del Month	ivery Day Year
rds, P	The law requires that the tee has been signed by the bage 2 should be detached.	by	Part II. Dther significant conditions contributing to death but not resulting in the	e undertying cause grven in Part I.	23e. Did tob	acco use contribute to s 2 No 3 ☐ Pr	
Record	(0)	Completed			24a. Whas an autopsy perform	prior to a	topsy findings available completion of cause of
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medicat examiner?	26. Place of Death			
of	hys this	1.70	27. Manner of Death 28a. Date of Injury 28b. Tim	tient 3 DOA 4 Nursing Hon		nce 6 Other (Spec w injury occurred	cify)
ion	Attending I r death. ector: After by the funer	atior	1 XNatural 5 ☐ Pending (Month, Ďaý Year) Inju 2 ☐ Accident investigation	y Work? M 1 ☐ Yes 2 ☐ No			
Division	al or Attending P s after death. Il Director: After i d in by the funers	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	street, factory, office	8f. Location (Str. City or Town,	eet and Number or Ru , State)	ral Route Number,
	To the Hospital or Attanwithin 24 hours after deat To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, or the basis of examination and/or and manner stated.	eath occurred at the time, date and place, a r investigation, in my opinion, death occurre	nd due to the car ad at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To T com	Σ	29b. Signature and title of certifier Otton	ling 19c. License number D10790		OCTOBER	
	1		30. Name and address of person who completed cause of death (Item 23a) (Ty	ne. Print)		BALTI	
			31. Date filed (Month, Day, Year) 32. Registrar's Signature	W. COLDSPRING	- LIV.	MD	21210
	Sta Regist		31. Date filed (Month, Day, Year) OCT 2 8 2004 32. Registrar's Signature	Sparks			

			1 - For State Registrar	State of	Maryland	/ Depa	artmen rtificat	t of H	ealth a Death	and M	ental Hyg	giene Reg. No.	2004	34281
	Physici		1. Decedent's Name (First, Middle, L	·	othy W:	inifr	ed	Shep	pard		2. Date of Dea Month	Day	Year	3. Time of Death 9:00 p
	/Medic Examir			11a			Cat	onsv	Location o			4c. (2004 County of Deal Balt	h O
	Funeral Director		5. Social Security Number 6. 214-40-8316 Usual Residence of Decedent	Sex 7. 1 ☐ M 2 🏋 F	Age (In yrs. lasi	Yrs.	Months	1 Year Days	If Under a	Min.	8. Date of Birtl (Month, Day	, Year)		hplace (State or Foreign untry) W - Va
	Maryland a-f show illed al	tor	10a. State 10b. County	/A	10c. City, T Balt		cation							10d. Inside City Limits ↑ Yes 2 □ No
	th with the 23e or 28 ust be not	rai Director	10e. Street and Number 529 E. Coldspr	ing Lane			10f. Zip		212			10g. Citiz U.S	en of What Co	untry?
036	a within 72 hours after death with the Maryland Jiene. r than "netural", or itams 23e or 28a-1 show the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 Tes 2 If Yes, Give Year or Date	ss? (7) No		Was Deced fYes, sped 1 ☐ Yes		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto l	city Yes or No- Rican, etc.)		 Race - Ame Black, White Specify: 	
Maryland 21215-0036	within ene. than *	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12) 12th grade		or 5+)	life. I		rk done d se retired)	uring most	of working	ng		d of Business/ timore	,
yland 2	ges 1 and 2 should be filed it of Health and Mental Hygi If item 27 ta marked other or other traumatic avent,	To Be C	17. Father's Name (First, Middle, La.	unk Unk					Alb	erta	(First, Middle, Diggs			
Mar	nd 2 shallth and 27 tam		19a. Informant's Name/Relationship Barbara_McFadde								<i>l Route Numbe</i> ne Ba1			
Baltimore,	Pages 1 and 2 nent of Health a int: If item 27 is iry or other trai		20a. Method of Disposition 1 🖾 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	☐Removal from Sta	20b. Plac	e of Dispo etery, cren	sition (Nar	ne of ther place	e)	D	7/2004_	20c. Loc	ation - City or	Town, State
Balti	permit. Page Department of Important: If any injury or		21. Si malure of Funeral Service Lic	, 19K	te	22	. Name an	430	s of Facility Wa	M .bash	larch F/ Avenue	H W Ba	est lto, Mo	
	Pnysician		23a. Pan 1. Enter the disease, or co shock, or heart hillure. List on Immediate Cause (Final disease or condition resulting in death)	mplications that cau y one cause on eac a	sed the death. I h line.	- 49	er the mod		1/29	cardiac o	r respiratory arr	est,		Approximate Interval Between Onset and Death
	/Medical Examiner	er	Sequentially list conditions, if any leading to immediate	b	as a consequen									
8760,	cate be executed obysician and the burial-transit	ledicai Examine	cause. Enter Underlying Cause (Underlying that initiated events resulting in death) Last	c. Due to (or	as a consequen	ace of):								
O. Box 68	death certifii e attending p d for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		n 2 ☐ Fetal de t at time of deat	ath 3[]Ectopic pr] Other (sp				p:======	23	3d. Date of deli Month	rvery Day Year
rds, P.	w requires that the been signed by th should be detache	by	Part II. Other significant conditions	contributing to deat	h but not resultir	ng in the u	nderlying c	ause give	n in Part I.			bacco us es 2 ⋤		the cause of death?
Vital Records,	The law ate has b page 2 si	Completed							-		24a. Was a autops perfor 1 🗆 Yes	med?	prior to death?	topsy findings available completion of cause of 2 No
	Physicien: 1 this certifical ral director, p	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 □ Inp	atient 2□ER	/Outpatien	it 3 DC	Othe	r		(Check only or ne 5 ⊠ Resid		Other (Spec	cify)
ion of	ding After fune	ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of (Month,		3b. Time of Injury		8c. Injury Work	at	2	28d. Describe h			,,
Division	ital or Attenors after death rs after death al Diractor; led in by the	Certification;	3 ☐ Suicide 6 ☐ Could not determine	d 286. Place of	Injury - At home , etc. <i>(Specify)</i>	a, farm, str	eet, factory	, office		2	28f. Location (S City or Town		Number or Ru	ral Route Number,
	To the Hospital or within 24 hours after To the Funeral Dirac completely filled in b.	Medical	(Check only 2 Medical Ex	Physician: To the beaminer: On the basi and manner	s of examination	idge, death and/or inv	vestigation	, in my op	inion, deat	d place, a h occurre	ed at the time, d	ate and p	place, and due	to the cause(s)
	D		29b. Signature and title of certifier	Kans					49			10	signed (Month	ley
_	('		30. Name and address of person wh	o completed cause	tod	ule	Print)	his	103	Colo	m1v.16	e m	7122	Y
	Sta Regist		31. Date filed (Month, Day, Year)	A.	istrar's Signature	6	100	rks	/					

State of Maryland / Department of Health and Mental Hygien 2004

1- State Amend 25, per ME, g866, 4/25/07 TT Certificate of Death 34282 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dạy Year **Physician** STEELE WILLIAM FRANKLIN 9:15 10 2004 26 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FRANKLIN SQUARE HOSPITAL CENTER ROSEDALE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth April, Day, Country)
Months Days Hours Min. April, Day, Zear 1954 MARYLAND 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 XM 2 ☐ F 220-66-0283 50 Director Usual Residence of Decedent the Maryland show 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other than "naturat", or Itams 23e or 28a-f show other traumatic evant, it a Madical Examinat must be notified at 1 ☐ Yes 2X No Director MD. BALTIMORE MIDDLE RIVER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 11 LYNBROOK ROAD U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ Specify: WHITE 3 Widowed 4 Divorced Year or Dates: 1973 and Mental Hygiene. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 LABORER CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be tand Mental F ROBERT HANEY SHELVIA STEELE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health ar CAROLE STEELE/WIFE 11 LYNBROOK ROAD, MIDDLE RIVER, MD. 21220 If itam 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ō permit. Page Department of Important: If any injury or once. BAYVIEW CREMATORY 10/30/04 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee ZZName and Address of Facility INC. FUNERAL HOME 700 S. CONKLING STREET, BALTO., MD. 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESPIRATORY FAILURE **Physician** disease or condition resulting in death) /Medical **Examiner** HEPATIC ENCEPHALOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER death certificate be executed ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 9 Unknown 9 Unknown s been signed by the should be detached Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 HEPATORENAL SYNDROME, MRSA 1 Tes 2 No 3 Probably 4 XUnknown Completed LIVER CIRRHOSIS 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed' 1 Yes 2 No 1 🗌 Yes 2 No After this certification, Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other 4 Nursing Home 5 Residence 6 Other (Specify) Yes 25 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pendina s after dec. М 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide ŏ within 24 hours a To the Hospitel 29a, Certifie 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AF 2328412-420 10126 Certiciole Amuelipe, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. OLUBUKOLA AMUDIPE 9000 FRANKLIN SQUARE DRIVE, BACTIMORE, 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature State OCT 2 8 2004 Registrar

			1 - For State Registrar	State of Marylar	nd / Dep <i>Ce</i>	partment of F ertificate of I	lealth and N <i>Death</i>	Mental Hygie Reg.		34283
	Physici	ian	1. Decedent's Name (First, Middle, La	ast)				2. Date of Death Month	Day Year	3. Time of Death
	/Medio Examin		4a. Fecility Name (If not institution, gir	ve street and number)		4b. City, Town, o	r Location of Death		27, 2004 4c. County of Death	(D)
	Funeral			Sex 7. Age (In yrs.	last birthda	/ASAD	If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	ANNE AR 9. Birth	place (State or Foreign
	Director		412-42-5967 Usual Residence of Decedent	10 M 200F 7	4 Yrs.	Months Days	Hours Min.	12-15-3	29 Miss	51551005
	aryland show	5	10a. State 10b. County	10c. Cit	ty, Town or I	Location				10d. Inside City Limits
	r 28a-f	irecto	10e. Street and Number	eundel th	SADI	10f. Zip Code		10g.	Citizen of What Cou	
	death with the Maryland ms 23e or 28a-f show r i ust be notified a	Funeral Director	7765 OLD 140	USERD.	e 12	211	122 ignapio Origina (Sa	positu Von er Ne	0:5.A	- P
9	permit. Pages 1 and 2 should be liled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department if time 27 is marked other than "naturelt, or Itams 23e or 28e-f show any injury or other traumatic event, the Madical Examiner mast be notified an once.	by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 Who If Yes, Give Year or Dates:	.3.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	spanic Origin? (3p in, Mexican, Puerto Specify:	Rican, etc.)	Bfack, White,	
ָה ה	"nature		15. Decedent's E (Specify only highest gr	ducation	16a. Dec	edent's Usual Occupi re kind of work done o DO NOT use retired	ation during most of work	king 16b	, Kind of Business/in	dustry
7	giene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	H	MEMA	KER	0	WN HO	ME
	buid be filed with Mental Hygiene arked other that atic event, the	Be	17. Father's Name (First, Middle, Last	ROSSWHIT	·c		18. Mother's Nam	e (First, Middle, Maid	den Sumame)	
lar y	z should and Men is marke sumatic	2	19a. Informant's Name/Relationship	Type, Print)		ling Address (Street	and Number or Rur	ral Route Number, Cit	ty or Town, State, Zip	Code)
≥ ່ນ :	Health (tem 27 I		EMUND TAYLOR 20a. Method of Disposition		Place of Disp	CENTRA position (Name of		SADENA, A-Date 20c.	1D. ZIZ Location - City or To	own, State
	Pages Iment of I Bant: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	(y) BA	WIEL		ORY 10-2	3-04 Ba	TIMORE!	MARYLAND
0	permit. Pag Department Important: I any injury o QBGB.		21. Signature of Fune all Service Lice	nsee O	3		amily Funeral Ho	me And Cremation		
			23a. Part1. Enter the disease, of comshock, or heart failure. List only	plications that caused the deat one cause on each line.	h. Do not e	nter the mode of dyin	g, such as cardiac	- Pasadena, MD. or respiratory arrest,	21122	Approximate Interval Between Onset and Death
	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a conseq	uence of):	arter o	5 trong Ca	mcer	1	Omos-
E	Examiner	J.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseq	uence of):		<u> </u>			
7	nd transit	Examiner	cause. Enter Underlying Cause (Disease or infury that initiated events resulting in death) Last	c						
00	ilcate be executed physician and s the burial-transit	edical Ex	resulting in wealth) cast	Due to (or as a conseq	uence of):					
00 YO	ding physe as the		IF FEMALE:	23c. If yes, outcome of pregna	2007					
.0.	to the nospite or Attending Priystolen: The law requires that the death certified to the control after the control of the Proposition of the Proposition of the attending completely filled in by the funeral director, page 2 should be detached for use as	Physiclan/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 MNo 9 ☐ Unknown	1 Live birth 2 Feta 4 Pregnant at time of d	death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of delive Month	ory Day Year
L (SD)	quires tra en signed t uld be det	þ	Part II, Dther significent conditions	contributing to death but not res	ulting in the	underlying cause give	en in Part I.	5.52	o use contribute to the	ne cause of death?
משני ו	ine law re ate has beo page 2 sho	Completed						24a. Was an autopsy performed	prior to cor death?	psy findings available inpletion of cause of 2 No
VILA	certifica rector, I	o Be C	25. Was case referred to medical examiner?	Hospital:		Othe	\r	h (Check only one)		
5	ng rnya fter this ineral d	⊢	1 ☐ Yes 2 ☑ No 27. Manner of Death 1.☑ Natural 5 ☐ Pending	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time Injury	SIL 3 DOA	4 Nursing Ho	28d. Describe how in	6 □Other (Specifi ijury occurred	/)
DISIA	of one nospite of versioning ringstoen; interial within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	2 Accident investigatio 3 Suicide 6 Could not be 4 Homicide determined	e Ogo Blace of Injury At he	ome, farm, s		Yes 2 □No	28f. Location (Street City or Town, Sta	and Number or Rura	l Route Number,
ב ב	hours at nerel D		29a. Certifier 1 Certifying Pl	nysician: To the best of my kno	wledge, dea	th occurred at the tim	e, date and place,	and due to the cause	(s) and manner as st	ated.
1	ithin 24 o the Fu	Medical	(Check only 2 Medical Exerone) 29b. Signature and title of certifier	niner: On the basis of examina and manner stated.	tion and/or i	29c. License			and place, and due to Date signed (Month, i	
1	7		1200	2 All		0	31551	0	tebero	28,2004
	8		30. Name and address of person who	(web-MB 3	05/	tospite	1 Drme,	G/ent	Win to	21061
	Sta Registr		31. Date filed (Month, Day, Year) OCT 2 8 20	32. Registrar's Signa	ture	doa v	,		ś	/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 5 per fth 9849 11-17-05 vt
State of Maryland? Bepartment of Health and Mental Hygier 0044

1 _ For

34284

Registrer			Cen	tificate of l	Death	Reg.	No.	
Physician Beatr		Veronica		Thorn		2. Date of Death 10/23/20	Pay Year	3. Time of Death 11:30 A M
Examiner 4a. Facility Name (If not institution, give street and tham Avenue	d number)		4b. City, Town, or Ft. Wash:	Location of Death ington		4c. County of Death Prince Geo	orge's
Funeral 5. S 21 9-56 579-01-1	836 1□M 21⊆	7. Age (In yrs. last b	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 070/12/3/19	9. Births Eng	place (State or Foreign Tand
Usual Residence of 10a. State Maryland	10b. County	e's 10c. City, To		eation hington			1	0d. Inside City Limits
4 2 2 2 10e. Street and Nu 7609 La	mber tham Avenue			10f. Zip Code	20744		Citizen of What Cour England	ntry?
Baltimore, Maryland 21215-0036 Bennit. Pages 1 and 2 should be lifed within 12 hours after death with the Maryland Department of Health and Mental Hygiene. Inportant: If item 27 is marked other traumatic event, the Medical Example minister of the mini	ried 2 Married 1	Decedent Ever in U.S. ed Forces? Yes 2 🛱 🎝 o s, Give or Dates:		/as Decedent of Hi Yes, specify Cuba ☐ Yes 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:	
ad within 72 hours aft gigene. Completed by Formal School	15. Decedent's Education cify only highest grade comple ondary (0-12)	oted) 16 oge (1-4or 5+)	a. Decede (Give k life. De HOI	ent's Usual Occupa ind of work done of O NOT use retired memaker	ation Juring most of worki)	ng 16b	In Home	
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supposed to the supposed to th	ame/Relationship <i>(Type, Print</i> C. Whipple / I						ty or Town, State, Zip ,MD. 20744	
Baltimore 20a Method of Dis 30a Method of Dis 4 □ Denation 5 ↑ 4 □ Denation 7 ★ □ Denation 21. Signatur of Fee	position MSremation 3 □Removal 5 □ Other (Specify)	cemet	ery, crema	ition <i>(Name of</i> atory or other place matory	10/25	101	Location - City or To gewater, M	
21. Signatur of Francisco	uneral Service Licensee	,					Funeral H 1, Marylan	
again Part Lenter 1 23 Part Lenter 1 23 Part Lenter 1 24 Part Lenter 1 25	on a	e to (or as a consequence	Ca. e of):		g, such as cardiac o		y nknown	Approximate Interval Bestween Onset and Death
res that the death certific signard by the attending by the attending by the attending by the attending by the attending by the attending by the base of the base	nonthe≔ 1□L 2No 4□F	s, outcome of pregnancy ive birth 2 Fetal deat Pregnant at time of death Jnknown		Ectopic pregnancy Other (specify)			23d. Date of delive Month	ry Day Year
A Part II. Other signification of the part	ficant conditions contributing	to death but not resulting	in the und	derlying cause give	on in Part I.		co use contribute to th	
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E 25. Was case refer examiner?	Hospital			Otho	26. Place of Death			
Sign of Death of Death	140	1 Inpatient 2 ER/O	utpatient Time of	3□ DOA 28c. Injury		ne 5 Residence 8d. Describe how in	6 Other (Specify)
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DIVI	determined 28e.	Place of Injury - At home, foulding, etc. (Specify)				City or Town, St		
Division of Vital Rec To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Diractor: After this certificate has completely filled in by the funeral director, page 2 completely filled in by the funeral director, page 2 completely filled in by the funeral director, page 2 completely filled in by the funeral director, page 3 certification: Medical Certification: Medical Complete According to the law within 24 hours after death. Medical Complete According to the law within 24 hours after death. Medical Complete According to the law within 24 hours after death. Medical Complete According to the law within 24 hours after death. Medical Complete According to the law within 24 hours after death. Medical Complete According to the law within 24 hours after death. Medical Complete According to the law within 24 hours after death. Medical Complete According to the law within 24 hours after death. Medical Complete According to the law within 24 hours after death. Medical Complete According to the law within 24 hours after death. Medical Complete According to the law within 24 hours after death. Medical Complete According to the law within 24 hours after death. Medical Complete According to the law within 24 hours after death. Medical Complete According to the law within 24 hours after death. Medical Complete According to the law within 24 hours after death. Medical Complete According to the law within 24 hours after death. Medical Complete According to the law within 24 hours after death. Medical Complete According to the law within 24 hours after death. Medical Complete According to the law within 24 hours after death. Medical Complete According to the law within 24 hours after death. Medical Complete According to the law within 24 hours after death. Medical Complete According to the law within 24 hours after death. Medical Complete According to the law within 24 hours after death. Medical Complete According to the law within 24 hours after death. Medical C		o the best of my knowledg he basis of examination a manner stated.	ge, death o nd/or inve	occurred at the time estigation, in my op	e, date and place, a inion, death occurre	nd due to the cause d at the time, date a	e(s) and manner as stand place, and due to	ated. the cause(s)
29b. Signature and	title of certifier			29c. License	number	29d. [Date signed (Month, L	Day, Year)
30. Name and addr	ess of person who completed	cause of death (Item 23a)	(Type, Pr			ville, no		
State 31. Date filed (Mon		32. Registrar's Signature	9	Sparker	,	- 1	- 0 3	

			1 - Stete Amend Item	State of Ma 1 per Dr.	aryland ,G836	1/Depa ,10/2	artme	nt of H	ealth an Death	nd Men	, 0		4	34285
	00		Decedent's Name (First, Middle, La								ate of Death			3. Time of Death
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			Holy Cross Hospi	tal					Spring			Monto	ome:	rv
	Funeral		5. Social Security Number 6. S	Sex 7. Agr IXIM 2□F	e (In yrs. la	st birthday)	If Und		If Under 24 Hours	Hrs. 8. C	ate of Birth		9. Birth	place (State or Foreign
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	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limits
	Mary f sho	ō	MD Prince	Coorgo	Lauı	rol								1 XYes 2 □ No
	28a-	Director	10e. Street and Number	George	паці	rei	10f. Z	ip Code			100	2. Citizen of W	/hat Cou	ntry?
	3a or	Ö	14327 Oxford Dri	Ve				707		1		J.S.A.		,
	death ms 2	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S		Was Dec	edent of Hi	spanic Origin	? (Specify	Yes or No-	14. Race		can Indian,
9	be filad within 72 hours after death with the Maryland ital Hygiene. od other than "natural", or Itams 23a or 28a-f show event, the Medical Examiner must be nutified at event, the Medical Examiner must be nutified.		1 Never Married 2 Married	Armed Forces? 1 XYes 2 ☐ N If Yes, Give				ecity Cubai	n, Mexican, P Specify:	ruerto Hicai	n, etc.)	Specify:	k, White,	
00	hours ural',	d by	3 Widowed 4 Divorced	Year or Dates:	L974-	76							BTS	
5	"nat	lete	15. Decedent's E (Specify only highest gra			16a. Deced	kind of w	ual Occupa ork done d use retired,	luring most of	f working	16	b. Kind of Bu	siness/Ir	ndustry
12	e filad within al Hygiene. I other than " vent, Ibe Mac	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	Engin		use retired,	,			communi	cati	one
9	filad Hygid other ent,	0	17. Father's Name (First, Middle, Last)					18. Mother's	Name (Fir:		iden Sumame		LOTIS
Maryland 21215-0036	should be nd Mental marked o	To B	Bernard Mark Ups	hur, Sr.					Blanc	che Fa	untler	.OA		
ary	shot nd N ma	_	19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	g Addre	s (Street a				City or Town, S	State, Zij	Code)
	and 2 alth a 27 is er tre		Betsy L. Upshur	/spouse		1432	7 Ox	ford	Drive,	Laur	el, Ma	ryland	207	07
ore	00-		20a. Method of Disposition 1 ☐ Burial 2 [XCremation 3 ☐	Damaval from State	20b. Pla	ace of Dispo	sition (Na	ame of other place	9)	Date	20	c. Location - (City or T	own, State
altimore,	Pages ment of ent: If its ury or o		'4 □ Donation 5 □ Other (Special		W.	Arunde	el Ci	cemato	ory Oc	et 26,	04 C	denton	, Ma	ryland
Balt	permit. Page Department Importent: Il eny injury o		21. Signature of Funeral Service Lice	nsee		22 D	. Name a	nd Addres dson	s of Facility Funera	al Hom	e, P.A			
	40700	Ш	220 Ports Enterthy disease or com	Ch.	M007								207	07-4389
П			23a. Part1. Enter the disease, or com shock, or hear failure. List only	one cause on each lir	ne deam.	Do not ent	er me mo	ae or aying	, such as car	ralac or res	piratory arresi	ι,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a _Cardiog										24 hours
	Examiner			Due to (or as		,								-
	3	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Cardion Due to (or as										5 years
	uted d ansit	Examiner	Cause (Disease or injury that initiated events	Systemi	c lup	ous er	ethe	mptos	is					20 years
o,	an an rial-tr	Еха	resulting in death) Last	Due to (or as	a conseque	ence of):								
38760,	icate be executed physician and s the burial-transit	edical		_ d										
_			IF FEMALE:											
Вох	death certif e attending d for usa a:	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 🗌 Fetal o	death 3□		oregnancy				23d. Date Mon		ery Dav Year
0		Physiclan/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant at 9□Unknown	time of dea	ath 5∟	Other (s	pecify)						Day real
<u>α</u>	that the de ad by the a detached f		Part II. Other significant conditions of	ontributing to death be	ut not result	ting in the ur	nderlying	cause give	n in Part I.	- 2	23e. Did tobac	co use contri	bute to t	he cause of death?
Records,	ed be	d by					, ,							pably 4 Dunknown
COL	> 0 0	lete								_	4a. Was an	24b W	loro auto	psy findings available
Re	The law cate has b page 2 st	Completed								-	autopsy performe	d? pr	rior to co eath?	mpletion of cause of
Vital	icien: Th certificate rector, pag	Be Co	25. Was case referred to medical						26. Place of		Yes 2	No 10	□ Yes	2 No
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lof	ding Ph After th funeral	n: T	27. Manner of Death 1 Manual 5 □ Pending	28a. Date of Injur (Month, Day		28b. Time of Injury		28c. Injury Work				injury occurre		,,
Siol	ttendir daath. ctor: Af	atic	2 Accident investigation	n		,,	М		es 2□No					
Division	or Attending ifter daath. Director: Aftel in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ry - At hom (Specify)	ne, farm, str	et, facto	ry, office		28f. L	ocation (Stree City or Town, S	et and Number State)	r or Rura	d Route Number,
	pitel urs a eral D		200 Continu	isian Tuta Lega										
	To the Hospitel or Attending Ph within 24 hours after daath. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one) 1 ☐ Certifying Pl 2 ☐ Medical Exar	nysician: To the best of niner: On the basis of and manner sta	examination	n and/or inv	estigatio	n, in my op	e, date and pi inion, death d	occurred at	ue to the caus the time, date	e(s) and man and place, ar	ner as sind due to	tated. the cause(s)
	Fo the within Fo the	Me	29b. Signature and the of certifier	///			29	c. License	number		29d.	Date signed	(Month,	Day, Year)
			> Duy 1	6				021	153		10	1-20-	-04	/
			30. Name and address of person who	completed cause of de	eath (Item 2	23a) (Type,	Ja "	SAR	RYI). Ru	BEN,	NO		
				MOSHERE	Arc	#Z01	Sic	VER	SPR	1NG,	Mal	1090	14	
• 2	Sta		31. Date filed (Month, Day, Year)	32. Registra	ır's Signatu	ILE				,			7-	
	Registr	ar	OCT 2 8 2004	Fleger	P	400	che							

		-	State of Maryland / Department of Health and Mental Hygieng 1 - State Registrar Certificate of Death Reg. No.	
			1. Decedent's Name (First, Middle, Last) 2. Date of Death	3. Time of Death
	Physicia			25 25 / 1:35 PM
	/Medic Examin		Ab Ch. Taum and another of Death	. County of Death
			ST. AGNES HEALTH CARE BALTIMORE	N/A
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 F 7. Age (In yrs. last birthday) Months Days Hours Min. Month, Day, Year)	Birthplace (State or Foreign Country)
١.	Director		216-34-6373 74 115. 08-25-19.	
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	Mary fied :	Ď	MD Baltimore Catonsville	1 2 Yes 2 □ No
	r 28e	Director	10e. Street and Number 10f. Zip Code 10g. Cir	itizen of What Country?
	23e o			, S , A .
	ams		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	hours after death with the Maryland tural, or Itams 23e or 28e-f show al Examinations by natified at	by Fu	1 Never Married 2 Married 1 Yes 2 No Specify:	Specify: Black
Maryland 21215-0036	thin 72 hours after death with the Marylan e. an "natural", or Itams 23e or 28e-1 show Madical Examilian mat be mulfied at			(ind of Business/Industry
75	within 72 ene. than "nai	Completed	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)	and of Datinood ingoodly
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פַ	be filed ntal Hygid ed other avant, I	Be C		n Sumame)
/al	should be nd Mental nmarked o	10		
lan	and and lam		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City True Cherie White	or Town, State, Zip Code)
	an F T 2		son - Doughter in law 3113 Jeffrey Kd. Baltimore	ocation - City or Town, State
ŏ	Pages 'nent of hint: If ite		1 Prayrial 2 Cremation 3 Removal from State	
altimore,	artmer artent ortent njury			uneral Home
Ba	permit. Pages 1 Department of H Importent: If iter any injury or ott		Wille Expuelly 4600 inherty Heights Au	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between
	Physician		Immediate Cause (Final	Onset and Death
7	/Medical		disease or condition resulting in death) Due to (or as a consequence of):	2 (1100)2
н	Examiner		Sequentially list conditions, b. Serscs	36 Heur
	po tis	iner	if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury Cause).	A
/	ecute and I-trans	Examiner	that initiated events resulting in death) Last Due to (or as a consequence of):	/ WEEK
8760,	cate be executed obysician and the burial-transit	aiE	<u>a</u>	
687	Phyaician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rat director, page 2 should be detached for use as the burial-transit	edicai	0 d	
Box	leath certific attending p I for use as	n/M	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	23d. Date of delivery
	death e atte	Physician/Me	in the past 12 months? in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Yes 2 No 9 Unknown	Month Day Year
P.0	that the de led by the a detached i	hys	9 Unknown	
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ord	v require been sig should t	ted	1 TYPE 2	P No 3 Probably 4 Unknown
of Vital Records,	has by	Completed	STROKE 24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
= H	yaician: The is certificate hadirector, page	Con	performed? 1 Yes 2 No.	death? o 1 Yes 2 No
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of	Phya this ral dir	. To	1 Ninpatient 2 EH/Outpatient 3 DOA 4 Nursing Home 5 Hesidence	
on	ding th. After	tion	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No	
Division	Atten r deal sctor	lfica	2 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street a building, etc. (Specify) City or Town, State	nd Number or Rural Route Number,
ā	s afte s afte el Dir	Certification:	building, etc. (Specify) City or Town, State	в)
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical		
	thin 2 the omplet	Med	one) and manner stated. 29b. Signature and title of certifier 29d. Date 29d. License number 29d. Date 29d	ate signed (Month, Day, Year)
	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		NO 20 AAA AAA AAAA PII PII 7 201	
	'n			0134 25, 2004
	')		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SYED U. MASOD GOD CATONS AVENUE BALTIMORE M.D., 212 at 31. Date filed (Month, Day, Year) 32. Registrar's Signature OCT 2 8 2004 Aparts Aparts	. 29,
	Sta		e 31. Date filed (Month, Day, Year) 32. Registrar's Signature	
Di	Regist		OCT 2 8 2004 Prima B sparks	

DHMH 17 Rev 1/2001

LILLIE WILKES

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar 34287 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** October 22, 2004 С. Waugh 7:30 Рм Mary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1913 1 ☐ M 2 🗓 F Washington 91 519-12-4489 October 6, Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28e-f show ast be notified at 1X Yes 2 □ No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23e or 20850 United States 8 Baltimore Road death y Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status other treumetic event, the Medical Examiner. Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural, or the eny injury or other treumetic event, Its Madical Exurities eny injury or other treumetic event, Its Madical Exurities 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Katherine Carr John Wall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15804 Amelung Lane, Rockville, Maryland 20855-1705 Joan P. McGuire/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) October 27, 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery Silver Spring, Maryland 2004 * 4 ☐ Donation 5 ☐ Other (Specify) Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 21. Signature of Funeral Service Licensee M01305 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Week Immediate Cause (Final disease or condition resulting in death) Respiratory Failure **Physician** /Medical Due to (or as a consequence of): Examiner 4 Days Overwhelming Sepsis Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed use as the burial-transit Pneumonia and Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 X No detached for Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9☐Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ pe 1 ☐ Yes 2 ☐ No. 3 ☐ Probably 4 X Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 24 No page 2 No 1 Yes 1 Yes To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifice 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 1 K Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No М investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide filled 🔣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2006/68 30. Name and address of person who completed cause of death (Ilem 23a) (Type, Print) 071 9901 Medical Center Drive, Rockville, Maryland 20850 Robert Kirkcaldy, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State sacked Registrar OCT 2 8 2004

State of Maryland / Department of Health and Mental Hygien 2004 34288 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Yeer **Physician** 8:00 AM M Leslie L. Weisher, Sr. October 22. 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Shady Grove Adventist Nursing Home Rockville Montgomery 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Months Hours Min. 1X M 2□ F 89 February 24, 1915 Director Connecticut 049-03-1716 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a, State 10c. City, Town or Location or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 X No Director Chevy Chase Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a 5630 Wisconsin Avenue #1004 20815 United States filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Affricas. 1 MYes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify: Specify: 3 Widowed 4 ☐ Divorced "natural", White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) 12 Machinist Manufacturing Pages 1 and 2 should be filed nent of Health and Mental Hygiant: If item 27 Is marked other other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be William Christian Weisher ပ္ Dora Lindhorn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5630 Wisconsin Avenue #1004 Chevy Chase, Maryland 20815 Joy W. Burbach/ Daughter 20b. Place of Disposition (Name of Windsor Veterans Memorial Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 'Department of H Important: If ite any injury or of 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 0ctober 26, 2004 * 4 ☐ Donation 5 ☐ Other (Specify) Windsor, Connecticut 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase. Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 21. Signature of Juneral Service Licensee M00335 Re 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition **Physician** Parkinson's Disease 5 Years /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. the attending physicien Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. Congestive Heart Failure 1 ☐ Yes 2 🛣 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Hypertension autopsy performed? Yes 200 No this certificate has Coronary Artery Disease 1 Yes or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation after death 2 Accident the f 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 - Homicide within 24 hours a To tha Funaral C Hospital filled 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D28656 October 22, 2004 30. Name and odress of person who completed cause of death (Item 23a) (Type, Print) 14 Ravi Passi, M.D. 15225 Shady Grove Road #208 Rockville, Maryland 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2 8 2004

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year October 26, 2004 **Physician** Harry Garfield Weaver 8:25 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** North Pines Care Home Manchester Carroll 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 13℃ M 2 🗆 F 213-01-7768 Yrs 84 Maryland **Director** Aug 28,1920 Usual Residence of Decedent filed within 72 hours after death with the Maryland show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "naturel", or items 23a or 28a-f shov treumatic event, the Would Examinate must be notified at Upperco 1 Yes 2 No Funeral Director Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5728 Emory Road 21155 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: white Specify: Be Completed by 3x Widowed 4 □ Divorced WII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Machinist 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F Is marked of be Garfield Weaver Annie Beam 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 If of Health Barbara Beck, daughter 3605 Hoffman Mill Road, Hampstead, MD 21074 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Page:
Department o
Importent: If
eny injury or ō 1 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremations 10/27/2004 Hampstead, MD 21. Signature of Fyneral Service Licenses 22. Name and Address of Facility M00723 Eline Funeral Home 934 South Main St, Hampstead, MD 21074 23a. Part1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dementi **Physician** /Medical Due to (or as a consequence of): Examiner COPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Figure Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-transit Cause (Disease or friju that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical use IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. the detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ page 2 should be 1 ☐ Yes 2 ☐ No 3 A Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No certificate has 2X No Physicien: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After To the Hospitel or Attending Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 51705 BUM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HESTMANSTER. MD 21157 340 m. PANSURIYA Bacom 31. Date filed (Month Day 32. Redistrar's Signature State Registrar

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ΙK	04-348			Please	Type or Print in Black Indelible Ink. Ensur	re All Copies Are Legible.	
M			_		State of Maryland / Department of Health a	and Mental Hygiene	
		1 - St	ate		State of Maryland / Department of Health a	2004	31

			For State Registrar		State	of Maryla		artment of F	lealth and N Death		giene Reg. No2 (104	34290
>	Physici /Medic Examir	al	1. Decedent's Nam Dameein 4a. Fecility Name (1 2510 SH)			Davo umber)	n	4b. City, Town, o	ite r Location of Death		ER 24,	Year 2004 ity of Death	3. Time of Death 2:50 P M
	Funeral Director		5. Social Security N		6. Sex 1X M 2 □ F	7. Age (In yr.	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	75 75	9. Birthp	place (State or Foreign ntry) MD
	aryland show	2	Usual Residence o 10a. State	Decedent 10b. County			City, Town or Lo					1	10d. Inside City Limits 1☑Yes 2□No
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21215-0036	within 72 horene. ene. then "nature the Medical E	Completed	Elementary/Seco	ondary (0-12)	grade completed,) (1-4or 5+)	(Give life. L	OO NOT use retired	during most of world)		16b. Kind of		
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Maryland	유 전 트 트	2	19a. Informant's N				19b. Mailir	g Address (Street	and Number or Ru			n, State, Zip	Code)
Baltimore, I	permit. Pages 1 and 2 Department of Health a Important: If item 27 ie eny injury or other tree <u>once</u> .		° 4 Donation 21. lig lature or Fi	position Cremation 5 Other (Sp	3 □ Removal from ecify)	State	Place of Dispo cemetery, crem pbutus M 4	sition (Name of natory or other plan Cemete Name and Addre arch F/ 300 Wab	ry 10/3 H West ash Ave	0/04 , Balt	Arbut	- City or To	21214 own, State Md 21215
200	Pnysician /Medical		23a. Part1. Enter shock, or hea Immediate Cause disease or condition resulting in death)	art failure. List o (Final	a	caused the de each line.	- gun	er the mode of dyir	Jourhas cardiac	or respiratory an	rest,		Approximate Interval Between Onset and Death
8760,	/Medical Examiner		Sequentially list or if any, leading to in cause. Enter this Cause (Disease or that initiated event resulting in death)	rinjury s	c	(or as a conse							
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	Hospital 4 hours a Funerel ely filled	edical Ce	29a. Certifier (Check only one)		xaminer: On the				me, date and place, pinion, death occur		ause(s) and r	nanner as si	tated.
	To the within 2 To the complet	Me	29b. Signature and	title of certifier	1 1	-		29c. Licens	e number	1	29d. Date sign		

t	2 ER/Outp	patient 3	DOA	4 Nursing	Home 5	5 Residence	6XOther
Yea	28b. Tii	me of full	28c. Injury a Work? 1 🗆 Ye	ut es 2 No		Describe how inju	

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29a. Certifier (Check only one)			death occurred at the time, date and place, a	and due to the cause(s) and manner as stated. ed at the time, date and place, and due to the cause(s)
29b. Signature an	nd title of certifier		29c. License number	29d. Date signed (Month, Day, Year)

29b. Signature and title of certifie

OCME

29d. Date signed (Month, Day, Year) OCTOBER 25, 2004

of person who completed cause of death (Item 23a) (Type, Print) TiKIn

111 Penn Street, Baltimore, Maryland 21201

State Registrar

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31. Date filed (Month, Day, Year) 0CT 2 8 2004 32 Aegistrar's Signature

		1	FOR	partment of Health and Ment ertificate of Death	al Hygiene Reg. No	711111	34291	
			Decedent's Name (First, Middle, Last)		ate of Death Ionth Day	/ Year	3. Time of Death	
	Physicia /Medic	_	William J.Woodl	and I	10 23	2004	1:45 p M	
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c.	4c. County of Death N/A		
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	Funeral Director		5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthd 215-12-0680 1 M 2 □ F 82 9rs	Months Days Hours Min.	ate of Birth Month, Day, Year) 7 28 1922	9. Birthp Coun	lace (State or Foreign try) Md	
		<u> </u>	Usual Residence of Decedent				0d. Inside City Limits	
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98	s 1 and 2 should be filed within /2 hours after death with the maryland if health and Mental Hygiene. if the atth and Mental Hygiene. if the 2 is marked other then "neturel", or items 23e or 28a-f show other treumatic event. The Madical Examinar must be notified at	by Funeral Director	Acroed Forces? 1 Never Married 2 Married 1 Syss 2 No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto Rican 1 ☐ Yes 2 No Specify:	n, etc.)	Black, White, Specify:	etc. Lack	
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Maryland	2 sho and is m		Tour morning to the second of	ailing Address (Street and Number or Rural Rou			Code)	
2	is 1 and 2 of Health a item 27 is other tree		620	10 Ashburton Street E		1 ZIZIO ocation - City or To	own. State	
Baltimore,	ges 1 t of H ff ite or ot		WBurial 2 ☐ Cremation 3 ☐ Removal from State	crematory or other place)				
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	_		23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac or res	piratory arrest,		Approximate Interval Between	
M.	Physician		Immediate Cause (Final				Onset and Death	
	/Medical		resulting in death) Due to (or as a consequence of)					
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	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Chonic Obstucti	ve Pulmonary Disease				
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.O. Box	at the death certificate be executed by the attending physician and tached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive Month	ery Day Year	
Д.	pa es		Part II. Other significant conditions contributing to death but not resulting in t	ne underlying cause given in Part I.	23e. Did tobacco	use contribute to t	he cause of death?	
rds	quires n sign ald be	d by	Hypertension		1 ☐ Yes 2	∏ No 3 ☐ Prob	bably 4 Unknown	
Records,	as been si 2 should	Completed			24a. Was an autopsy	24b. Were auto	opsy findings available impletion of cause of	
Re	9 7 9	mo			performed? 1 ☐ Yes 2 🔀 No	death?	a∏ No	
Vital	icien: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?	26. Place of Death (Ch	neck only one)			
_f <	Physicien: this certific ral director,	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp				fy)	
n of	Jing Ph J. After th funeral		27. Manner of Death 1 ☐ Watural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Tir	iry Work?	Describe how inju	ry occurred		
Sio	Attending or death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury: At home, farm	M 1 Yes 2 No	Location (Street a	nd Number or Rur	al Route Number.	
Division	or Attendated death Director:	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, State			
	pspite hours unerel ly filled	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.	death occurred at the time, date and place, and or investigation, in my opinion, death occurred a	due to the cause(s t the time, date an) and manner as s d place, and due t	stated. o the cause(s)	
	To the Howithin 24 To the Fu	Me	29b. Signature and title of certifier	29c. License number	29d. Da	ate signed (Month,	Day, Year)	
)			Joshus R. Wilchell	MD. D08782		10-26-04	4	
	X		30. Name and address of person who completed cause of death (Item 23a) (T	ype, Print)				
	b'		Joshua R. Mitchell, III, M.D., 220	O Garrison Blvd., Balt	o. Md 21	216		
		ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	& Sports				
	Regist	rar	MILL O COOT	- Johnson				

			-	For State	State of Ma	ryland / Dep <i>Ce</i>	ertificate of	Health and M Death		gier 2 0	4	34292
				Registrar 1. Decedent's Name (First, Middle, La	st)				2. Date of Dea	uth		3. Time of Death
_		Physicia /Medic		Jessie	Má	arie	Wes	st	Month Octob	er 24	Year 2004	5:35PM
1		Examin		4a. Facility Name (If not institution, given				or Location of Death		4c. County		
4				Stella Maris M			Baltimo					
8		Funeral		5. Social Security Number 6. S	Sex 7.Age I□M 2 X □F	(In yrs. last birthday	Months Days		8. Date of Birtl (Month, Da)	, Year)	Coul	
tober 34,300		Director	-	214-24-4116 Usual Residence of Decedent		76			11 1	9 27		IC
B.		show		10a. State 10b. County		10c. City, Town or I	ocation				1	10d. Inside City Limits
0		death with the Maryland rms 23a or 28a-f show	Director	MD NA		Baltim	ore					1 XYes 2 No
0		or 28	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cou	ntry?
to		s 23a		3720 Yosemite	Ave			21215	acifu Vac or No	U.S		can Indian,
Es		ter de Itam	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	lo	If Yes, specify Cub	Hispanic Origin? (Spean, Mexican, Puerto	Rican, etc.)	Bla	ck, White,	
0	936	urs af	þ	3 XWidowed 4 ☐ Divorced	1 ☐ Yes XXN If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specif	/: E	Black
1	1215-0036	72 ho natur	Completed	15. Decedent's E	ducation ade completed)	(Giv	edent's Usual Occup re kind of work done	during most of work	ing	16b. Kind of B	usiness/In	dustry
U.	12	Aithin ne.	du	Elementary/Secondary (0-12)	College (1-4or 5	+} /ife.	DO NOT use retire	(d)			-	
9	2	illed v Hygie thar t nt, tr		12th grade	na na	La	b. Techr	nician 18. Mother's Name	e (First, Middle,			Company
12	land	d be f ental l ced o	To Be	Grover C. Harr	,			Robert			,	
1 >	37	shoul nd Me meri	<u>-</u>	19a. Informant's Name/Relationship		19b. Ma	ling Address (Street	and Number or Rura			State, Zip	o Code)
1	Ž	alth a alth a 127 is		Chestine Winst	on-Daught	ter_ 372	O Yosemi	ite Ave,	Balti	more,	Md	21215
8	altimore,	es 1 a of He fitam roth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 [Removal from State	20b. Place of Dis	position (Name of ematory or other pla		Date	20c. Location	City or To	own, State
B	Ĕ	Pag ment tant: I		4 ☐ Donation 5 ☐ Other (Special	fy)	Loudon	The second secon		9/04	Baltim	ore,	Md
7	Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f shoven yinjury or other traumatic avant, Ite Medical Examinat must be netitied at once.		21. Signal re of Funeral Service Lice	nsee S	M	^{22. Name and Addre arch F/H 300 Waba}	ess of Facility I West ash Ave,	Balti	more,	Md	21215
				23a. Part1. Enter the disease, or con shick, or hear vailure. List only	plications that caused one cause on each lin	the death. Do not e	nter the mode of dyi	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
	M	Physician		Immediate Cause (Final disease or condition	a	100	o car					Onset and Death
		/Medical Examiner		resulting in death)	Due to (or as	a consequence of):						
	н	LAUITIMO	_	Sequentially list conditions,	b. Due to (or as	a consequence of):						
		ted nsit	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (61 as	a consequence or,						
		ate be executed only sician and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):						
	8760,	ohysicial	dlcal		d							
	68	tificate g phys	Medi	IS SELVALE.								
	30X	The law requires that the death certific Ite has been signed by the attending p bage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	□Ectopic pregnanc	:y			te of delive	ery Day Year
	O. E	e dea the at hed fo	sici	1 Yes 2 No	4□Pregnant at 9□ Unknown	time of death 5	☐ Other (specify) _					52,
	Θ.	hat th ad by detacl	Phy	Part II. Other significent conditions	contributing to death b	ut not resulting in the	undertving cause on	ven in Part I.	23e. Did to	baçco use con	tribute to t	he cause of death?
d	ds,	signe d be	d by	100					1,21	es 2 No	3 ☐ Prot	bably 4 Unknown
1	cor	w requ	Completed						24a. Was	an 24b.	Were auto	opsy findings available
	Re	sicien: The law certificate has b irector, page 2 s	dwo						autop perfo 1 ☐ Yes	rmed?	prior to co death? 1 □ Yes	
	ta		Be C	25. Was case referred to medical				26. Place of Deat			10163	2010
	Ž	nysici nis cer direc	To B	examiner? 1 ☐ Yes 2,☑ No	Hospital: 1 ☐ Inpatie	nt 2□ER/Outpat	00 0011	her: 4 Nursing Ho	me 5 Resid	lence 6 🗷 Oth	er (Speci	m hospice
	Division of Vital Records, P.O. Box 6	ng Pl		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. Time y Year) lnjury	Wo		28d. Describe h	now injury occur	red	
	sio	tandi leath. tor: A	catl	2 Accident investigation 3 Suicide 6 Could not		At home form]Yes 2 □No	29f Location /6	Street and Numi	or or Pur	al Route Number,
	Σį	or At after of Dirac in by	Certification:	4 Homicide determine		ury - At home, farm, c. (Specify)	street, ractory, omice		City or Tox		or or nur	ar noble rumber,
	_	spital tours naral filled		29a. Certifier 1 Certifying F	hysician: To the best	of my knowledge, de	ath occurred at the ti	ime, date and place,	and due to the	cause(s) and m	anner as s	stated.
		To the Hospital or Attanding Physicien: within 24 hours after death. To tha Funaral Diractor: After this certifica completely filled in by the funeral director.	Medical	(Check only one) Medicel Executed National Medicel National Medicel National Medicel National Me	miner: On the basis of and manner sta	examination and/or	investigation, in my	opinion, death occur	red at the time,	date and place,	and due t	o the cause(s)
		To the within To the comp	×	29b. Signature and title of certifier	^		29c. Licen	se number		29d. Date signe	1	
		1		> DNI M	~ / ~		Pr	108511		101	251	2009
		H		30. Name and address of person who	0.1	eath (Item 23a) (Typ	e, Print)				-	
				31. Date filed (Month, Day, Year)		ar's Signature	PL 100	dimort	mcl.	5150	L	
		Sta Regist	ate rar	QCT 2 8 2	004	ever f	Spark	2				

		1	1 - State of Man	yland / Depa <i>Cer</i>	artment of H tificate of L	lealth and Me Death	ntal Hygier	2004	34293
	Physicia		1. Decedent's Name (First, Middle, Last) James William Wilfong				Date of Death	ax Solfat	3. Time of Death 8:10 FM
)	/Medic Examin	al er	4a. Facility Name (If not institution, give street and number)	Center	4b. Cily, Town, or	Location of Death	1	ic. County of Dear	timore
	Funeral Director		5. Social Security Number 234-44-0587 6. Sex 1 X M 2 □ F 7. Age (a	In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min. J	Date of Birth (Month, Day, Yea Uly 26,	9. Bin We \$	hplace (State or Foreign T ^{ntr} Virginia
	rland Iow		Usual Residence of Decedent 10a. State 10b. County 1	0c. City, Town or Lo	cation				10d. Inside City Limits
	Ba-fst	ctor	Maryland Baltimore	Timonium	T	***			1 □ Yes 2√ No
	3a or 2	i Dire	1206 Longford Road		10f. Zip Code 21093			Citizen of What Co	untry?
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinating the incilling at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever Armed Forces? 1 Married Forces? 1 Married Forces? 1 Married Forces? 1 Married Forces?	ı	Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2 1 No	ispanic Origin? (Speci in, Mexican, Puerto Ri Specify:	ty Yes or No- can, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.
Maryland 21215-0036	ithin 72 hou ne. nan "natura nedical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Deced (Give life. L	DO NOT use retired	during most of working f)		Kind of Business	
d 21	e filed wat Hygier other the		12 5+ 17. Father's Name (First, Middle, Last)	Ulsab	ility Pol	icy Specia 18. Mother's Name (Governme en Sumame)	n c
/lan	2 should be f and Mental H is marked of raumatic eve	To Be	Clayborne Wilfong			Henriett	a Gainer		
Mar	d 2 sho th and th sma traum		19a. Informant's Name/Relationship (Type, Print) Dori Wilfong/Wife		•	and Number or Rural F Road, Timo		or Town, State, 2 21093	Zip Code)
d)	of Health of Health I Item 27 r other tr		<u> </u>	20b. Place of Dispo		manage of the second	te 20c.	Location - City or	
Baltimore,	permit. Pages 1 Department of H Important: If Ite any injury or ot once.		'4 □ Donation 5 □ Other (Specify) 2) Signal re of Funeral Service Licens	Hilltop S			0/2004	Towson,	
Ba	Depared Impo			saao :	1050 York	ss of Facility Ruck Road, Tow	lowson son. MD	1 21204	Home, Inc.
			23a Part 1. Enter the disease, or complications that caused the shock, or heart ailure. List only one cause on each line.	ne death. Do not ent	er the mode of dyin	g, such as cardiac or r			Approximate Interval Between Onset and Death
	Pnysician /Medical		resulting in death) a	dYOCARDI					
	Examiner .		Sequentially list conditions.	CORONAR	Y ARTER	Y DISEASE	60-9 77 90-9		YEARS
	uted d ansit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	consequence of):					
,0928	sician and burial-transit			consequence of):					
9	ificate I g physi as the b	ledicai	d						
O. Box	at the death certificate be executed by the attending physician and tached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tire 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	ivery Day Year
s, P.	The law requires that the tte bas been signed by the bage 2 should be detache	by	Part II. Other significant conditions contributing to death but	not resulting in the u	nderlying cause give	en in Part I.			the cause of death?
Il Record	(6)	Completed					24a. Was an autopsy performed?	death?	utopsy findings available completion of cause of
Vital	Phyaician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	2 ☐ ER/Outpatien	it 3□ DOA Oth	26. Place of Death (er.	Check only one)	6 Other (See	nife!
of	ding Phya h. After this funeral di	H.	27. Mann f Death 1 atural 5 Pending (Month, Day)			y at 28	d. Describe how in		ony
Division	or Attendent fler deat lirector: n by the	Certification:	2 Accident investigation	/ - At home, farm, str (Specify)		Yes 2 □No	f. Location (Street City or Town, Sta	and Number or Ri ate)	ural Route Number,
_	lospli hour unera	Medicai Co	29a. Certifier (Check only one) Certifying Physician: To the best of 2 Medical Examiner: On the basis of e and manner state	xamination and/or in					
)	To the P within 24 To the F complete	Me	29b. Signature and title of cartifier. Wallow, M. 7).	29c. Licens	e number 25886	29d. [Date signed (Mont	1. Day, Year) 2004
	5+1		30. Name and address of person who completed cause of dea		,	OWSON MAI	RYLAND.	21204	
	Sta Regist			0: . /	ports				

			For State Registrar	State of Maryla		artment of H			giene Reg. N2 0 0 4	34294
	Physici	an	Decedent's Name (First, Middle, Last)	VASLICK				2. Oate of De Month	ath Day Year	
	/Medic Examin		4a. Facility Name (If not institution, give stre	eet and number)		4b. City, Town, or		ath OCT	4c. County of De	ath
	Funeral		5. Social Security Number 6. Sex		last birthday)	If Under 1 Year Months Oays	5 A If Under 24 H Hours Mi		HOWAR th Yearl 9. B	inthplace (State or Foreign Country)
	Director		214-62-3617 Usual Residence of Decedent	2 F	52 Yrs.	Month of Cays	110010		er 14, 1952	Pennsylvania
	aryland show	-	10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits 1 Yes 2 No
	the M. 28e-f	Director	Maryland How 10e. Street and Number	ard		10f. Zip Code	Ilicott City		10g. Citizen of What 0	
	th with	al Di	8014 Notingham Way				21043	3		J.S.A.
36	72 hours after death with the Maryland natural; or Items 23e or 28e-f show deal Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in the Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1	Was Decedent of Hi fYes, specify Cuba 1 ☐ Yes 2 No	spanic Origin? n, Mexican, Pue Specify:	(Specify Yes or No arto Rican, etc.)	14. Race - An Black, Wh Specify:	nerican Indian, nite, etc. White
2-00	"natural", or	sted	15. Decedent's Educal (Specify only highest grade of	ion	16a. Dece	dent's Usual Occupa kind of work done of	ation furing most of w	ronkina	16b. Kind of Busines	
21215-0036	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired,	tail Sales			Retail
	be filed tal Hygi d other event,	Be Co	17. Father's Name (First, Middle, Last)	1.5		116		ame (First, Middle,	, Maiden Sumame)	
Maryland	Men Men arke	To	Frank Josep		10h Mailie	on Address (Street a	and Number or	Pum/ Pouto Numbe	Sayo Noda	Zio Codol
	12: h ar 7 la trau		Mr. Frank Waslick	Father		1975			arvland 21043	, Zip Code)
Baltimore,	Pages 1 and nent of Healt int: If item 2 iry or other		20a. Method of Disposition 1 Burial 2 Cremation 3 Ren	20b.	Place of Dispo	sition (Name of matory or other place		Date	20c. Location - City of	or Town, State
Ħ	permit. Pag Department Importent: I any injury o		*4 □ Domation 5 □ Other (Specify) 21. Sonatule of Funeral Service Licens e	A	County C	remation Ser	vices, Inc.	10/27/2004	Sykesv	ille, Maryland
Ba	permit. Departm Importer any inju		Mundalla 16	1 mis		Slack I	Funeral Ho	me, P.A.	H City MD 040	40
Ĺ			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	cause on each line.				_		Approximate Interval Between Onset and Death
	Pnysician /Medical		Imhediate Cause (Final trease or condition sulting in death)	A CUTE K Due to (or as a conse		ATOKY	DISTR	Ell ?	YNDROME	1 WEEK
	Examiner		Sequentially list conditions, b.	PNEUMO						8 days
	uted 1 Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conse		ER FAI	LURI	=		2 WEEKS
8760,	sate be executed physician and the burial-transit	dical Exa	resulting in death) Last	Due to (or as a conse	- 43				1A OF THE LIVE	ER 3 MONTHS
9	rtificate ng phys a as the	0	IF FEMALE:							
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and cage 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 M No 9 Unknown	If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	aldeath 3□	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
	quires that the signed by ald be detacted.		Part II. Other significant conditions contri ZIVE CIRRHOSI	S		nderlying cause give	en in Part I.		obacco use contribute Yes 2 ⊠ No 3□F	to the cause of death? Probably 4 □Unknown
Records,		Completed by	REMOTE ALCO	HOL ABU	ISE			24a. Was autor perfo 1 ☐ Yes		
Vital	Physician: this certifica ral director, i	Be	25. Was case referred to medical examiner?	pital:		othe Othe	Ar.	eath (Check only o	опе)	
of	Physical distribution	n: To	27. Manner of Death	1 ☑ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time o	28c. Injury	at at		dence 6 Other (Sp how injury occurred	ecify)
sion	Attending death. ctor: Afte y the fun	catlo	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	NONE	Injury		Yes 2 □ No			
Division	l or Attend after death Director: I in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, sti ify)	eet, tactory, office		28f. Location (S City or Tov	Street and Number or l vn, State)	Rural Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Medical C		ien: To the best of my kn r: On the basis of examin and manner stated.						
	To the vithin To the comp	W	29b. Signature and title of certifier	201 000	VC.C.	29c. License		-	29d. Oate signed (Mor	
	X		Mussell Ouren 2 30. Name and address of person who com		CC-) (T	D-1-t)			OCT, 25,	
	1,		RUSSELL ONENS	HUB 188	75 C	ENTRE.	PARK	DRIVE	SUITED,	COLUMBIA
ţ·	Sta Regist		31. Date filed (Month, Day, Your) 8 200	32. Registrar's Sign	nature &	Lone			,	

			For State Registrar	State of M	Marylan		artment rtificate			and M	-	Reg. No.	000:	34295
	Physici /Medic Examin	an al	1. Decedent's Name (First, Middle Anne T Yu 4a. Facility Name (If not institution Saint Josep	kna n, give street and numbe		d- a-s	4b. City, T	own, or	Location o	of Death	Month OCTOB	Day ER 3	County of Deat	
	Funeral Director		5. Social Security Number 212 07 7521 Usual Residence of Decedent			last birthday) Yrs.	If Under 1 Months	l Year Days	If Under a		8. Date of Bin (Month, Da March 3	1916	9. Birt	hplace (State or Foreign funity) imore, Mary Land
	ne Maryland 8a-f show	ector	10a. State 10b. County Maryland Baltimo	ore City		y, Town or Lo imore			_					10d. Inside City Limits 1 Yes 2 No
	r death with ti ams 23a or 2 acroust be ri	Funeral Director	10e. Street and Number 6510 Walther Avenu	ne Apt B8	nt Ever in U.	.S. 13.	10f. Zip (2120 Was Decede	6	spanic Orig	gin? (Spe	ecify Yes or No	USA	14. Race - Ame Black, Whit	ncan Indian,
21215-0036	72 hours after death with the Maryland Insturet; or Itams 23a or 28a-f show diest Exactinate matter milital at	Completed by Fu	1 ☐ Never Married 2 ☐ Marr 3 ☑ Widowed 4 ☐ Divorced 15. Deceden (Specify only highes	ied 1 ☐ Yes 2 € If Yes, Give Year or Dates t's Education	No	16a. Dece	1 ☐ Yes 2 dent's Usual kind of work	Occupa	Specify:				Spooife:	ite
	a filed within al Hygiene. other than "	Be Comple	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle,	College (1-40	r 5+)	Clerk	DO NOT use	e retired))		(First, Middle.		irance In	dustry
Maryland	nd 2 should b lth and Ments 27 Is marked r traumatic e	Tof	Frank Jones 19a. Informant's Name/Relations Deborah A Hansen			T.		(Street a		or Or Rura	l Route Numbe		r Town, State, 2	Zip Code)
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Itams 23a or 28a-f show amy injury or other traumatic event, the Mudical Examinet rest traumatic avent, the Mudical Examinet rest traumatic avent, the Mudical Examinet rest traumatic and once.		20a. Method of Disposition Y∑ Burial 2 ☐ Cremation '4 ☐ Donation 5 ☐ Other (S	3 □Removal from Sta		Place of Dispo emetery, crei kwood Co	esition (Name matory or oth enetery	e of her place Octo	ber 27	7 2004	ate	20c. Lo	cation - City or	
Ba	Department Department Impo		21. Sign fure of Funeral Service 23a. Part1. Enter the disease, or shock, or heart failure. List	complications that aus	ed the death	1 74		air F	Road Ba	altim	re, Maryl		21236	Approximate Interval Between
	Physician /Medical Examiner	er	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	RATIO as a consequence		UMON:	IA_						Onset and Death
8760, -	icate be executed physician and s the burial-transit	Ilcal Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or a	as a conseq	uence of):								
.O. Box 6	death certil le attending ed for use a	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcon 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 ☐ Feta at time of d	Ideath 3	Ectopic pre ☐ Other <i>(spe</i>					2	23d. Date of deli Month	ivery Day Year
Records, P	een sign	by	Part II. Other significant condition	ons contributing to death	but not res	ulting in the u	nderlying ca	use give	n in Part I.		23e. Did to		_	the cause of death?
Vital Rec	The la ate has page 2	e Completed	25. Was case referred to medica	I					26. Place	of Death		rmed? 2/21 No	24b. Were au prior to death?	topsy findings available completion of cause of
of V	d is	To B	examiner? 1 🗌 Yes 2 🗶 No	Hospital: 1 🔭 Inpa	tient 2	ER/Outpatier		_	4 140	rsing Hor	ne 5 ☐ Resid	dence 6	5 □Other (Spec	cify)
Division o	Attending Ph r death. sctor: After th by the funeral	Certification:	27. Manner of Death 1 Natural 5 Pendin 2 Accident investin 3 Suicide 6 Could	gation not be 380 Place of	Day Year)	28b. Time o Injury	М		at ? ′es 2 ☐ ľ	No	28d. Describe h			ıral Route Number.
Div	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	al Certii	4 Homicide determ	building,	etc. (Specify	y) wledge, deat	h occurred a	t the tim	e, date and	d place, a	City or Tow	vn, State)	and manner as	stated.
	To the Ho within 24 To the Fu complete!	Medical	29b. Signature and title of certifie	Examiner: On the basis and manner	stated.				number	th occurre		29d. Date	e signed (Monti	h, Day, Year)
,	,1		30. Name and address of person			m . D		0 4:	1412		0	o do	hcr 25	16, 2004.
10	Sta Regist		31. Date filed (Month, Day, Year) QCT 2 8 2	4	strar's Signa		lon	DRI	, ,,,,	OWSE	IN MOR	ALDI	ND SIS	74
	3	. W. St.	- WUIN W Z	UU4 /	~-	1	Aires	10:31						

DHMH 17 Rev 1/2001

ORIGINAL

		,	For	State of Maryland			7		34296
		7	State Registrar 1. Decedent's Name (First, Middle, in the control of the control	Last)	Certificate of		Reg. No.		3. Time of Death
	Physicia /Medic	ın	Charles, E.		lerson		Month Day		4:30PM
1	Examin		4a. Facility Name (If not institution, g		4b. City, Town, o	or Location of Death	40.	. County of Death	
-	Formers		Shady Grove Adv 5. Social Security Number 6	entist Hospital Sex 7. Age (In yrs. las	Rockvi st birthday) If Under 1 Year	If Under 24 Hrs. 8	. Date of Birth	Montgome 9. Birthp	ery lace (State or Foreign ltry)
	Funeral Director		215 36 4123	7. Age (In yrs. last	Yrs. Months Days		(Month, Day, Year) [uly 14 19		ington,D.C.
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location		7	1	0d. Inside City Limits
	Mary a-f sho	tor	Maryland Mont	gomery Rock	ville				1 ☐ Yes 2 🙀 No
	or 28	Director	10e. Street and Number	Bomer,	10f. Zip Code		10g. Cit	tizen of What Coun	ntry?
	leath v		629 Lincoln Stre	12. Was Decedent Ever in U.S.		850 Hispanic Origin? (Speci pan, Mexican, Puerto Ri	fy Yes or No-	USA 14. Race - Americ	
36	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other then "neturel", or liems 23e or 28e-f show them 27 is marked other then "neturel", or liems 23e or 28e-f show gitter traumatic event, the Modical Examination until be motified at	by Fun	1 Never Married Married 3 Widowed 4 Divorced	Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:	If Yes, specify Cub		can, etc.)	Black, White, Specify: Wh:	etc. ite
21215-0036	72 hou		15. Decedent's (Specify only highest	Education grade completed)	16a. Decedent's Usual Occu (Give kind of work done	during most of working	16b. K	and of Business/Inc	dustry
121	within ene. then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	`life. DO NOT use retire Firefighte	•	Mon	tgomery	County
2 pc	e filed at Hygi other vent, L	Be Co	17. Father's Name (First, Middle, La	ast)		18. Mother's Name (First, Middle, Maider	Sumame)	
Maryland	ould b	일	Alfred V. Ander		19b. Mailing Address (Stree	Mildred		or Town State Zin	(Code)
Mar	nd 2 sh Ith and 27 is m		19a. Informant's Name/Relationship Mary J. Anderso		629 Lincoln				20850
ore,	of Hear	li	20a. Method of Disposition 1 XBurial 2 Cremation 3	20b. Pla	ace of Disposition (Name of	Dai	te 20c. L	ocation - City or To	
Baltimore,	Page Iment tent: If		'4 □Donation 5 □ Other (Spe	Gat	e of Heaven C				
Ball	permit. Pages 1 Department of H Importent: If ite any injury or of		21, Signature of Funeral Service	Lewan		ess of Facility Hines Hampshire			,MD 20904
	Pnysician		shock, or heart failure. List of Immediate Cause (Final				respiratory arrest,		Approximate Interval Between Onset and Death 2 days
7	/Medical Examiner		disease or condition resulting in death)	Due to (or as a conseque	nced lung	Control of Control			м 4 год 3
	Lxammer	e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseque	ence of):				
	cuted Id ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	с					
760,	sician and burial-transit	I Exa	resulting in death) Last	Due to (or as a conseque	ence of):				
687	9 × 10	edical		d					
Вох	death certificat e attending phy id for use as th	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal (су		23d. Date of delive	ery Day Year
O. B	0 00 0	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of dea 9 ☐ Unknown	ath 5 ☐ Other (specify)			World	Day / Jan
Δ.	tha de de	by Ph	Part II. Other significant condition	ns contributing to death but not resul	lting in the underlying cause g	iven in Part I.	23e. Did tobacco	use contribute to th	he cause of death?
ords	v requires been sign should be						1 ☐ Yes 2	□No 3□Prob	pably 4 Unknown
Records,	e law r has be ge 2 sh	Completed					24a. Was an autopsy performed?	prior to con death?	ppsy findings available mpletion of cause of
Vital F		e Col	25. Was case referred to medical			26. Place of Death (1 ☐ Yes 2 € No	1 ☐ Yes	2
Ž	ys dis	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☑Inpatient 2 ☐ E	ER/Outpatient 3 DOA	thor	e 5 Residence	6 ☐Other (Specif	(y)
n of	ng ifter	1.0	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	(Month, Day Year)	28b. Time of 28c. Injury W	uryat 28 ork? ⊒Yes 2 ⊒No	3d. Describe how inju	ry occurred	
Division	l or Attending efter death. Director: After i in by the fune	Certification	2 Accident investigation of Could not determine determine	ot be One Place of Injury - At hor	me, farm, street, factory, office		Bf. Location (Street a. City or Town, Stat		al Route Number,
Ö	- 9 c	Cert							
	To the Hospitel or Attenwithin 24 hours effer deatl To the Funeral Director:	edical	29a. Certifier 1 Certifying (Check only 2 Medical E	g Physician: To the best of my know xaminer: On the basis of examinati and manner stated.	wledge, death occurred at the ion and/or investigation, in my	time, date and place, an opinion, death occurred	d at the time, date an	d place, and due to	o the cause(s)
	To the Hospitel or within 24 hours eff To the Funeral D completely filled in	Me	29b. Signature and title of certifier	1.1	29c. Licer	nse number		ate signed (Month,	Day, Year)
	10		▶ Chushe	aporne /	200) (7 200)	61549	/	0/12/	4
	(-		30. Name and address of person w	vho completed cause of death (Item	23a) (Type, Print) 1 Medical Cent	er Drive R	ockville,	Maryland	20850
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) OCT 15 2	32. Registrar's Signat	y Spark	www.			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 2004 34297 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 4:39 PM **Physician** Alkire Marshall 0 20-2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 15417 Shamrock Road Cumberland Allegany If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country)
 MD 8. Date of Birth (Month, Day, Year) Mar 1, 1953 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2□ F 218-64-9256 Director Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or then "naturel", or Items 23a or 28a-f show the Medical Examiner must be notified at MD Allegany Cumberland 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21502 15417 Shamrock Road USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Tes 2 No 1 ☐ Never Married 2 Married Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give ? Year or Dates: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) labor relations coordinator MeadWestvaco permit. Pages 1 and 2 should be file Department of Heatth and Mental Hy, Importent: If Item 27 is marked othe any injury or other treumatic access. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Irvin R. Hare Dorothy J. Crawford Hare 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Debra Alkire wife 15417 Shamrock Road Cumberland MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place)
Restlawn Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 10/25/2004 LaVale MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, P.A. 21. Signature of Funeral Service Licenses 108 Virginia Avenue: Cumberland, MD 21502 Part1. Enter the disease, or complications that saus shock, in heart failure. List only one cause on each Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed burial-transit Due to (or as a consequence of): the attending physician Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 100 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 Tyes 2 No Certification: To this To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 ENatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of pentil 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gary Wagoner M.D.
31. Date filed (Month, Day, Year) 925 Bishop Walsh Drive Cumberland MD 21502 32. Registrar's Signature State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #5. Per FH PCC 10-15-04 cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Owen Q 10 /Medical HOSPITA 4a. Fecility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Fort Washington Fort Washington Hospital Prince Ge orge MD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Societ Security Nu 2052 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) West **Funeral** Months 157M 20 F Yrs. **Director** Jamaica, Indies 23 160 Usual Residence of Decedent 10a, State 10b Counts 10c. City, Town or Location 10d. Inside City Limits ir then "natural", or Items 23a or 28a-f shov the Medical Examinar must be notified at 1XYes 2 ☐ No Director Maryland Prince Georges Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9604 Traverse Way 20744 **United States** Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Ant: If item 27 is marked other then "natural", or Items 23 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Eastern Electric Elementary/Secondary (0-12) College (1-4or 5+) years Electrician Company of Health and Mental Hygie f item 27 is marked other I r other treumetic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Alexander Newton **Elfreda** Graham 2 19a. Informant's Name/Relationship (Type, Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marcia Simpson Alexander 9604 Traverse Way; Fort Washington, Maryland 20744 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Oct. 23, 2004 Department of the Importent: If ite eny injury or of once. 1 Number Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) George Washington Cemetery Adelphi, Maryland 22. Name and Address of Facility
R. N. Horton Company Morticians, Inc.
600 Kennedy Street, N.W.; Washington, D.C. 20011 21. Signature of Funeral Service Licensee Coremen 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Gliobla Immediate Cause (Final Enysician toma 10 months disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, narry, leading to immediate cause. Enter Underlying Cause (Disease or injury Dise to for as a consequence of; Examiner The law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medicai IF FEMALE: use . If yes, outcome of pregnancy 1□Live birth: 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4 Pregnant at time of death 5 Other (specify) o 9 Unknown ۵ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 Yes 2 No 3 Probably 4 X Unknown Be Completed page 2 should 24a. Was an autopsy performed?
1 ☐ Yes 2 **K** No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1 ☐ Yes Hospital or Attending Physicien: director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Z Yes 2 No Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Funerel 6 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item-23a) (Type, Print) Southern Ave. SE#317 Washington, DC raghi K. Asadi, MA 1328

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

1 5 2004

VOID

CERTIFICATE

04-34299

S E E

CERTIFICATE #

etal #04-00797

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. 18. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** October 14, 2004 10:20 p.M. William McArthur Butler /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital St. Mary's Leonardtown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Sept. 23, 6. Sex Birthplace (State or Foreign Country) **Funeral** Year) Days 1**X** M 2□F Months Hours Min 57 Yrs. 1947 219-48-4674 Director Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ehow. r than "natural, or Items 23a or 28e-f ehov the Modeal Examiner must be notified at XXYes 2 No Director Maryland St. Marv's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1 28706 Lawrence Avenue 20650 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. be filed within 72 hours after 1 ☐ Yes 2X No If Yes, Give 1 Never Married Married Maryland 21215-0036 1 Yes 200 Specify: Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Waterman 12 Marine Construction ith end Mental Hygie 27 is marked other r treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James A. Butler Mary Rozena Edelen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peges 1 and 2 ment of Heelth e ent: if item 27 is Violet L. Butler / Wife P.O. Box 2441, Leonardtown, Maryland 20650 other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ö Department of importent: if any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial Gdns 10-20-2004 Leonardtown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. David A. Goff Q1095 22955 Hollywood Road, Leonardtown, MD 20650-0279 23a. Part1. Enter the disease, or comblications that caused to shock, or heart failure. List only one dayse on each tine Approximate Intervat Between Opset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): en Te MY OCHEDING INFARETION Pnysician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed physician and the burial-transit Exami Due to (or as a consequence of): Box 68760, Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 X Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy rector, page 2 2 No 1 Yes Hospitel or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi 28c. injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 l B E 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) nm 014581 10-20-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Boyd II, M.D. 25365 Point Lookout Road Leonardtown, Maryland 20650 31. Date fited (Month, Day, Year) 32 Registrar's Signature State OCT 2 0 2004 Registrar

		For State Registrar	State of Maryland	Certific	cate of E	eaith and Death	wentai Hy	gle 2 e0 (04	34301
hysici	an	1. Decedent's Name (First, Middle, Last,					2. Date of De Month	ath Day	Year	3. Time of Death
/Medic		MARTHA ELMIE	BOLLO				October	1	2004	9:50 P M
xamin	er	4a. Facility Name (If not institution, give 601 Quaint Acres		4b.		Location of Deat Spring	h		nty of Death	***
neral		5. Social Security Number 6. Sec.			Jnder 1 Year	If Under 24 Hrs		h	1t gome 9. Birth	place (State or Foreign
ector		578.48.4227]м 2⊈Г 84	Yrs. Mo	nths Days	Hours Min.	Dec. 2	y, Year) 2,1919	Cou	nsylvania
>		Usual Residence of Decedent 10a, State 10b, County	100 City	. Town or Location						
i i	5									10d. Inside City Limits 1 ☑ Yes 2 ☐ No
ig i	Director	Maryland Montgome	ry Ca	abin Joh	n. Xr. Zip Code			10g. Citizen o	of What Cou	
3		6525 76th Street			20818			U.S.A		ridy:
8	Funeral	11. Marital Status	12. Was Decedent Ever in U.S		Decedent of His	spanic Origin? (S	pecify Yes or No	- 14. R	lace - Ameri	
Na of the	۵	1 ☐ Never Married 2 ☐ Married 3 📆 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	If Yes	, specify Cubar ′es 2 ⊠ No	Specify:	to Rican, etc.)	В	Black, White, cify: Whi	
Sal B	ted	15. Decedent's Edu		16a. Decedent's			dia-	16b. Kind of	Business/In	ndustry
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2	Con	9th		Home					Home	
even	Be	17. Father's Name (First, Middle, Last)				_	me (First, Middle,			
atic	Jo.		zee			Laura	Cathari		mberst	
raum		19a. Informant's Name/Relationship (T)					ıral Route Numbe			
eny injury or other traumatic event, the Medical Eracifrer must be notified at once.		Joyce M. Locklin/ 20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ F	20b. Pl	601 Qua ace of Disposition metery, cremator	(Name of		e, Silve	er Spri 20c. Location		
gg dg		'4 □ Donation 5 □ Other (Specify)	Fort	Lincol	n Cemet	ery 10/1	15/2004	Brentwo	ood, M	[aryland
eny inj		21. Signature of Funeral Service License	e tie				RAL HOME		Spring	g,MD 20904
dical inner transit the parial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence). Due to (or as a consequence). Due to (or as a consequence).	ence of).						
hed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3□Ecto	pic prøgnancy er (specify)				Date of delive Month	ery Day Y <i>e</i> ar
be detac	by Pr	Part II. Other significant conditions co	ntributing to death but not resu	Iting in the underly	ring cause give	n in Part I.	23e. Did to	bacco use co		he cause of death?
70							1 🗆 1	′es 2□No	3 ₩ Prob	bably 4 □Unknown
CV	Completed						24a. Was autop perfo 1 Yes	an 24b sy rmed? 2 12 No	o. Were auto prior to co death? 1 ☐ Yes	ppsy findings available mpletion of cause of
pag	0	25. Was case referred to medical examiner?	Jaanital:				ath (Check only o			
	B	4 ED V 0 ED V-					lome 5 Resident			Daughter Residence
funeral director,	To B	27. Manner of Death 1 X Natural 5 □ Pending	(Month, Day Year)	N	1) 11 17					
in by the funeral director,	To B	27. Manner of Death	28a. Place of Injury - At hos building, etc. (Specify	ne, farm, street, fa			28f. Location (5 City or Tox		mber or Rura	al Route Number,
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygie 0 0 4 1 - For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 0 **Physician** 2004 Dorothy J. Blaisdell 8:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) Feb. 26, 1931 Birthplace (State or Foreign Country)
 New York 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months Hours 1 □ M 2/CXT 73 **Director** 212-30-3450 Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itams 23a or 28a-f show traumatic evant, It e Modical Exerciner must be notified at Arnold 1 ☐ Yes 2 X No Anne Arundel Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21012 U.S.A. 1264 Dogwood Road Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after of Hygiene.
Hygiene.
ther than "natural", or ital 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Specify: ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 Pages 1 and 2 should be filed venent of Health and Mental Hygies and: If itam 27 is marked other the source of the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frederick T. Holzapfel Helen Walling 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robert A. Blaisdell/husband 1264 Dogwood Road Arnold, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State injury or Baltimore Crematory 10/16/2004 Baltimore, MD permit. Page Department Important: If any injury o ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Feneral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician 2 MPHYSEM A ف الدرا و /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Year in the past 12 months?
1 Yes No
9 Unknown Month Day 4☐Pregnant at time of death 5 Other (specify) the detached 9☐ Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown NONE Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attanding Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Appatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 2 this s after death.

I Diractor: After this of in by the funeral d 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier OCT 12, 2004 D59037 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2002 Medical Parkway Annapolis, Maryland 21401 DOUGLAS 5 MITCHELL 31. Date filed (Month, Day, Year) 32. State OCT 14 2004 Registrar

	State of Maryland / Department of Health and Mental Hygiene
	1- State Registrar Certificate of Death ReQuir 14 34303
Physician	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 3. Time of Death
/Medical Examiner	Anthony F. Bailey 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Examiller	Southern Maryland Hospital Clinton Prince George's
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Nonths Days Hours Min. 8. Date of Birth (Month, Day, Year)
Director	Usual Residence of Decedent
laryian show ed et	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □ Yes 2 □ No
1036 Just atter death with the Marylan rati, or Itams 23a or 28a-1 show Examination at the nutitied at the Figure 1 bit of the control of the property of the	Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
23a o	2511 Kayhill Lane 20715 USA
M. String the death value of the result of	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
15-0036 172 hours after dear "netural", or items edical Examination in the interpretable of t	1 □ Never Married 3 □ Married 1 □ Yes 2 □ No 1 □ Yes, Give Year or Dates: 1957-60 1 □ Yes 3 □ No Specify: Specify: Black
d 21215-0036 d 21215-0036 lifed within 72 hours after death with the Maryland Bygiene. Unter them "natural", or Itams 23a or 28a-1 show ant, the Medical Examiliar of the Completed by Filmeral Director	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
212 212 d withi giene. or than	Elementary/Secondary (0-12) College (1-4or 5+) 12th 0 Computer operator Census Bureau
Ind hille that Hydra of othe evant,	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
Maryland 21215-0036 Maryland 21215-0036 at 2 should be filed within 72 hours att the and Mental Hygiene. 27 Is marked other than "natural", or traumatic event, the Medical Exc. of Tro Re Completed by E	Albert Bailey Lila Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mand 2 is and 2 is all the ar trau	Audrey B. Bailey (Wife) 2511 Kayhill Lane Bowie, Maryland 20715
Jore Jore Jore Hart Hern or oth	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 1 Constitution Cemetery, crematory or other place) 1 Constitution Cemetery, crematory or other place) 1 Constitution Cemetery, crematory or other place) 20c. Location - City or Town, Slate 20d. Brentwood, Md.
Baltimore, Maryland 21215-00; permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural any injury or other traumatic event, the Medical Expanse.	21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Ba Ba Ba Ba Ba Ba Ba Ba Ba Ba Ba Ba Ba B	Zarry M. Reese & Sons Mortuary, P.A. 821 West St. Annapolis, Md. 21401
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate finterval Between Onset and Death
Physician /Medical	Immediate Cause (Final disease or condition resulting in death) a. METASTATIC LIVER CANCER Due to (or as a consequence of):
Examiner	Immediate Cause (Final disease or condition resulting in death) a. METASTATIC LIVER CANCER Due to (or as a consequence of): b. UNITNOWN PRIMARY Due to (or as a consequence of):
axecuted an and ial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.
axecul	that initiated events c
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Box 68 eath certificat attending phy for use as th	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of delivery
Records, P.O. Box 68760, The law requires that the death certificate be axecuted ate has baan signed by the attending physician and page 2 should be detached for use as the burial-transit	In the past 12 months? 1 Yes 2 No Old Helicons
hat the de ed by the detached	9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
Records, F elaw requires the has baan signed ge 2 should be de	1 Yes 2 No 3 Probably 4 Unknown
Il Record The law requir	24a. Was an aulopsy findings available prior to completion of cause of
	performed? death? 1 □ Yes 2 ■ No 1 □ Yes 2 □ No
47th of Vital Physician: rthis certifica	25. Was case referred to medical examiner? 1 Tes 2 No 1 Infinity 1 Infinity 2 ER/Outpatient 2 ER/Outpatient 3 DOA 26. Place of Death (Check only one) 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)
Antina Physician: After this certific funeral director,	27. Manner of Death 1 MeNatural 5 Pending (Month, Day Year) 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred
Signature Speak	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town State)
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Co the Hospital within 24 hours a vitin 24 hours a To the Funeral E completely filled	29a. Certifier (Check only onl) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
To the within Virtue	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
	> Shot (hum, MD) 050862 OCTOBER, 12, 2004
	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)
State	31. Date filed (Month, Day, Year) 32. Phistrar's Signature
Registra	OCI 14 COUT PROPERTY OF PROPERTY OF THE PROPER

State of Maryland / Department of Health and Mental Hygiene 0 1 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** WILLIAM JOSEPH BOYLE OCTOBER 15 2004 $3 \cdot 12$ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8. Date of Birth (Month, Day, Year) FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☑ M 2 ☐ F 87 August Washington DC Director 578-09-4722 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County works ir then "natural", or Items 23e or 28e-f show the Medical Exemper must be notified at 1 ☐ Yes X☐ No Maryland Frederick Directo Walkersville 28e-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States Items 23e 9913 Paddock Lane 21793 Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Yes 2 New II 1 Never Married 25 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Automotive Industry other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If tiem 27 Is marked oth eny lipiny or other traumatic event ORRs. Be Elva Nelson 2 Daniel Boyle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) William Boyle, Jr. / Son 9913 Paddock Lane Walkersville, MD 21793 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Resthaven Mem. Garden 10-19-04 Frederick, MD ^ 4 □ Donation = 5 □ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licenses 1621 Opossumtown Pike Frederick, MD 21702 Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. (List only one cause on each life. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner burial-transit or Attending Physicien: The law requires that the death certificate be executed that initiated events physician and resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the ald 1 ☐ Yes 2 ☐ No Diwision of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 □ Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan page 2 s autopsy 2 No 1□ Yes director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Other: Hospital: 2 No 3 DOA 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? in by the funeral 28b. Time of 28d. Describe how injury occurred 27 Manger of Death Certification: Ailter Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death Disector: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide To the Hospital within 24 hours a To the Funeral (29a. Certifier 🗺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. onel 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier My My 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KSt, WAlkersuillemo 32. Registra 's Signature 31. Date filed (Month, Day, Year) State OCT 18 2004 Registrar

			For State Registrar	State	of Mar	yland / Dep <i>Ce</i>	artment or <i>rtificate</i>			nd Mei	ntal Hyg R	iene 2.C	04	3	4305
			1. Decedent's Name (First, Middl	e, Last)						2.	Date of Deat		V		3. Time of Death
п	Physici		George F. Brow	m							Month October	Day 16			7:05 A M
	/Medic Examin		4a. Facility Name (If not institution		ımber)		4b. City, To	wn, or Lo	ocation of		CLODE		County of De		
	2270011111	•	Kline Hospice	House			Mt.	Air	• • • •				Freder	ick	
_	Funeral Director		5. Social Security Number 216-14-5699	6. Sex 1 M 2 □ F		n yrs. last birthday, 86 Yrs.	If Under 1	Year II	fUnder 24 Hours	4 Hrs. 8. Min. M	Date of Birth (Month, Day, lay 24,	Year) 191	9. B 8 Ma	Birthplac Country	ce (State or Foreign
	D		Usual Residence of Decedent												
	rylar		10a. State 10b. County		11	0c. City, Town or L	ocation							10d	I. Inside City Limits
	e Ma	Director	Maryland Fred	lerick		Freder	ick								12 Yes 2 □ No
	or 28	Oire	10e. Street and Number				10f. Zip C				1	0g. Citi:	zen of What	Country	/?
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	r dez	Funeral	11. Marital Status	12. Was De Armed F	cedent Eve	er in U.S. 13.	Was Deceder If Yes, specify	t of Hispa	anic Origii Mexican,	n? (Specify Puerto Ric	y Yes or No- an, etc.)	1	14. Race - An Black, Wh		
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and	2 should be f and Mental h Is marked of raumatic ever	Be c	John Brown					"			illman		ourname,		
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Maryland 21215-0036	d 2 s th an 7 ls		Fern Brown / Wi				erry C							, 21p U	000/
Ġ,	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. It will them 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Ever intermisal be notified at		20a. Method of Disposition			20b. Place of Disp	sition (Name	of	1	Date	9	20c. Lo	cation - City of	or Town	n, State
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Ba	permit. Pages 1 Department of H Importent: If its any Injury or ot once.		The transfer of the second	1/54			100 No								
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Box	leath certific attending p	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o								2	3d. Date of d	elivery	
m	death a atte	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Preg	nant at tim		⊒Ectopic preg ⊒ Other (s <i>pec</i>						Month	Da	ay Year
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9	The law requires that the death certificate has been signed by the attending tage 2 should be detached for use as	by P	Part II. Other significant conditi	ons contributing to	death but r	not resulting in the u	nderlying cau	se given i	in Part I.		23e. Did tob	oacco u	se contribute	to the	cause of death?
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ta		C	25. Was case referred to medica					21	& Place o	of Death /C	1 ☐ Yes 2 Check only on	2 28 100	1 🗆 Ye	es 21	Z/No
5	Physiclen: this certificated director.	0 8	examiner? 1 ☐ Yes 2 (X No	Hospital:	Inpatient	2 ER/Outpatie	nt 3 DOA	Othor			5 ☐ Reside		Other (Sp	nacih)	Hospice
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Division	or Attending after death. Director: After in by the fune	ifica	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 286. Plac	e of Injury	· At home, farm, st	reet, factory, c	ffice		28f.				Rural A	loute Number,
Ö	el or s afte il Dir	Certification;	4 Hollicide	Dull	ding, etc. (Specify)					City or Towr	, State)			
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	To the Hospitel or Attending i within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	one)	Examiner: On the and ma	nner state	d.	vestigation, in	my opini	ion, death	occurred	at the time, di	ate and	place, and di	ue to th	e cause(s)
	To t To t	Σ	29b. Signature and title of certifie	r			29c. L	icense n	umber	ຄ /			signed (Moi		
)			1/4./	2		mi) 1-	, –	1	8	0 (10	tober		8,2004
	Co 1		30. Name and address of person	who completed car			Print)		_	-					
	4+1					Thomas	John	2000	Driv	re, t	reder	ick	MD	,21	702
	Sta Registr		31. Date filed (Month, Day, Year,	1 8 2004	Hegistrat's	Signature	9.	100	US)	,					
	11091511	-	901		/	/		1							

Brittingham

			1 - State Registrar	State of Maryland		artment of H		, ,	ne 2004	34307
	Dhusisi		1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medio		Paul Raymond	Brown, Jr.				October	13 200	4 /-/ A.M
	Examir	ier	4a. Facility Name (If not institution, give			4b. City, Town, or	Δ.		4c. County of De	I
			MANSKIN MANOR 5. Social Security Number 6. Se		ast hirthday)	PRINCE:		S. B. Date of Birth	0.8	rthplace (State or Foreign
Н	Funeral Director		213-22-4788	0M 2□F 76	Yrs.	Months Days	Hours Min		ear) (ryland
	ъ		Usual Residence of Decedent					12-29-19	ZI Ma	
	show	h.,	10a. State 10b. County	10c. City	, Town or La	cation				10d. Inside City Limits 1 Tyes 2 No
	86-1 86-1	50	MD Somerse	t Pri	ncess					
	with the	ă	10e. Street and Number			10f. Zip Code		10g	. Citizen of What C	Country?
	eath	Funeral Director	33067 West Post Of	fice Road 12. Was Decedent Ever in U.S	S. 13 V	218 Was Decedent of H		Specify Yes or No.	USA 14. Race - Am	erican Indian
'	r Item	F	1 ☐ Never Married Married	Armed Forces? 1 X Yes 2 ☐ No	ĺ		in, Mexican, Puer	Specify Yes or No- to Rican, etc.)	Black, Wh	
ဗ္ဗ	urs a		3 ☐ Widowed 4 ☐ Divorced	MYes, Give Year or Dates: WWII		1 □ Yes 📉 No	Specify:		Specify:	White
2-0	be filed within 72 hours after death with the Maryland nat Hygiene. Id other than "neturel; or items 23e or 28e-1 show of other than "neturel; or items 23e or 28e-1 show event, the Medical Examinar must be notified at	Completed by	15. Decedent's Edu (Specify only highest grad	ication	16a. Deced	dent's Usual Occup- kind of work done	ation during most of wo	nrkina 16	b. Kind of Busines	
7	ofthin nan Mar	ğ	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NDT use retired	1)			
2	lied w lygier her ti		17. Father's Name (First, Middle, Last)	none	Pou1	try Growe		me (First, Middle, Ma	Poultry	
and	t be f	Be	Paul Raymond Brow	7m C.w				e Smullen	den Sumame)	
2	2 should be filed v and Mental Hygie Is marked other reumatic event, the	ို	19a. Informant's Name/Relationship (Tr		19b. Mailin	a Address (Street		ural Route Number, C	itv or Town, State.	Zip Code)
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other treumatic a		Cecelia E. Brown/					·		nne, MD 21853
ē,	f Healthean		20a. Method of Disposition	1 00	ace of Dispo	sition (Name of natory or other place	!		c. Location - City o	
Ë	Page ent o nt: If ry or		Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	Removal from State		Cemetery	. 1	16-2004 P	rincess	Anne. MD
alti	mit.		2) Signature of Funeral Sovice Licens		22	. Name and Addres	ss of Facility		1 Incess 1	inine, in
ä	SOE S		14000 XXIII	MAD AL MOO!		nman Fune 673 Somer		e ., Princes	s Anne. N	m 21853
		1)	23a. Part1. Enter the disease, or compleshock, or heart failure. List only of	lications that caused the death	. Do not ente	er the mode of dyin	g, such as cardia	c or respiratory arrest	,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Lu	ng cu	var				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):					
П	Examiner	_	Sequentially list conditions,	D						
	be tis	line	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ence of):					
	and and II-tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequ	ence of):					
8760,	cate be executed physician and the burial-transit	a E		` _ `	· .					
687	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi	edical		1.				7.44		
Вох	leath certific attending p	Z	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar		1			23d. Date of de	elivery
Ď.	death e atte	S	in the past 12 months? 1 ☐ Yes 2 ⊡ No	1 Live birth 2 Fetal 4 Pregnant at time of de		Ectopic pregnancy Other (specify)			Month	Day Year
P.O.	that the de ed by the detached	hys	9 Unknown	9□Unknown						
S, I	es tha igned be de	by Physician/Me	Part II. Other significant conditions con	ntributing to death but not resu	lting in the ur	nderlying cause give	en in Part I.			o the cause of death?
Division of Vital Records,	w require been sign	Completed		MSEV 17				1 ☐ Yes	2 □ No 3 □ P	robably 4 20nknown
ecc	ne law r has be ge 2 sh	ple						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
<u> </u>	The l	5				_		performed 1 ☐ Yes 2 ☑		s 2 No
Vita	ilcien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othe	Ar. /	ath (Check only one)		
of	Physicien: r this certifica ral director, p	٦.	1 Yes 2 No	1 Inpatient 2 E	R/Outpatien 28b. Time of	1 3 DUA	4 Lanursing F	lome 5 Residence		ecify)
ü	ding h. After fune	tion	1 ☑ Natural 5 ☐ Pending	(Month, Day Year)	Injury	28c. Injury Work	k? Yes 2∐No	20d. Describe now	injury occurred	
<u>is</u>	Attending r death. ector: After by the fune	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At hor	me, farm, stre			28f. Location (Stree	t and Number or R	ural Route Number,
<u>S</u>	after after Direct	Certification;	4 Homicide	building, etc. (Specify,)			City or Town, S	itate)	
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical C	(Check only 2 Medical Exami	sician: To the best of my know ner: On the basis of examinati	vledge, death ion and/or inv	occurred at the tim restigation, in my op	ne, date and place pinion, death occu	e, and due to the caus urred at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
	thin 2 the o the	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. License	number	29d.	Date signed (Mon	th, Day, Year)
	£ 3 ₽ 8		> When							
7			30. Name and address of person who co	ompleted cause of death (item	23a) (Tyne	Print)	1 7		1-1.7/0	7
200						11510~ S	7,	SHISBUA	Y MD.	21804
-tr	Sta Registr	_	31. Date filed (Month, Day, Year)	32. Register's Signatu	ure #	(barte)				

Paul R. BROWN

State of Maryland / Department of Health and Mental Hydiene

tate of Maryland / Department of Health and Mental	Hygiene .	0.1
tate of Maryland / Department of Health and Mental Certificate of Death	Reg. No. U	U H

			1 - State Registrar			Ce	rtificate	of E	eath			Reg. No	004	34308
	Physici	an	1. Decedent's Name (First, Middle, La							2	2. Date of De Month OCT •	ath		3. Time of Death
	/Medi	ćal.	WALTER JOHN		mbasl		At City To		allata : -	(D 1)	ocr.	14ª,		
	Examir	ner	4a. Facility Name (If not institution, given PENINSULA REGION			TER	4b. City, To	JISE		or Death		40	. County of Dea WICOMIO	
	Funeral		5. Social Security Number 6. S	Sex IDXM 2□F	7. Age (<i>In yr</i> s. 77		If Under 1 Months [Year Days	If Under a		B. Date of Bir Month Da	th ly,_Year)	9. Bir	thplace (State or Foreign
	Director		Usual Residence of Decedent	CAL CO.		Yrs.					9-19	2/	NE	W JERSEY
	faryland show		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							10d. tnside City Limits
	ith the Ma or 28a-1 s	Director	DELAWARE SUSSE	X		MILLSB								1 ☐ Yes 2 ☐ No
	th with th	Dir	10e. Street and Number 33 HUNTER'S POIN				10f. Zip C						tizen of What Co	ountry?
	death	nera	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13.	Was Deceder If Yes, specify	966 nt of His	panic Orig	gin? (Spec	ify Yes or No	<u>US</u>	14. Race - Ame	
21215-0036	be filed within 72 hours after death with the Maryland hal Hygiene. Id other then "naturel", or Items 23a or 28a-1 show event, it a Medical Erachi er must be froithed at	d by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	1 [X] Yes If Yes, Gi Year or D	orces? 2 No 12- ve vates:	9 <u>-45</u> 12 <u>-4</u> 6	1 ☐ Yes 20	_	Specify:	, FUERO NI	ican, etc.)		Black, Whi	
15-(n 72 hours "naturel", edical Ere	Completed	15. Decedent's E (Specify only highest gr			16a. Dece (Give	dent's Usuat (kind of work DO NOT use	done du	ion <i>iring</i> most	of working	7	16b. K	ind of Business	/Industry
212	e filed within I Hygiene. other then "	шо	Elementary/Secondary (0-12)	College (1-4or 5+)		L ENGI					EN	GINEERI	NG
	be filed tal Hygie d other	Be C	17. Father's Name (First, Middle, Last)					18. Mothe		First, Middle			
Maryland	2 should be and Mental Is marked o	7	JOHN BLAHA			140 000	1. 17.00	L		SIE				
Mar	ロモトラ		19a. Informant's Name/Relationship (CONSTANCE V. BLA										or Town, State, . 19966	Zip Code)
e,	s 1 and of Health item 27 other tr		20a. Method of Disposition		20b. F	Hace of Disno	sition (Name	of		Da			cation - City or	Town, State
Baltimore,	permit. Pages 1 an Department of Heal Importent: If item 2 eny injury or other ance.		1 ☐ Burial 2 X Cremation 3 ☐ '4 ☐ Docation 8 ☐ Other (Speci		State ME]	CSON 'S' NLOPEN	CAPE CREMA	TORY	$z \mid_{1}$	0-18-	-2004	FRA	NKFORD.	DELAWARE
3alt	permit. Departe Importe eny inj		21. Signature of Fuper I Strice Lice	100	/	M	ELSON	Address FUNI	of Facility	SERVI	CES,L		RE. 199	
	40300		23a Part 1. Enter the disease or com	unlications that	caused the deat	h. Do not ent	ONG NE	CK I	CD,MI	LLSBC	ORO, DEI	LAWA	RE. 199	Approximate
	Physician		23a. Part 1. Enter the disease, or comshock, or heart failure. List only immediate Cause (Final					or dyning.	0001143	0210100 071	iospiiatory a	11031,		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)		(or as a conseq		WIR7							
	Examiner		Sequentially list conditions,	b										
	ted nsit	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (uisease of injury	Due to	(or as a conseq	uence of):								
Ć	execuin and ial-tra	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a conseq	uence of):								
68760,	ate be hysicia he bui	Ical		_ d										
39 X	certificate be executed rding physician and ise as the burial-transit	/Medical	tF FEMALE:	220 H van ov	tcome of pregna						-			
.O. Bo	The law requires that the death c ate has been signed by the attent bage 2 should be detached for us	Physician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live t	oirth 2 Feta nant at time of d	Ideath 3□	Ectopic preg Other (spec						23d. Date of dei Month	ivery Day Year
<u>α</u>	res that thigned by	by Ph	Part II. Other significant conditions	contributing to d	eath but not res	ulting in the u	nderlying cau	se giver	in Part I.		23e. Did t	obacco u	use contribute to	the cause of death?
rds	w requires been sign should be										10	/es 2	No 3□Pr	obably 4 Unknown
Vital Records,	e law re has bee	Completed									24a. Was autop		24b. Were au	stopsy findings available
E R		Con									1 Yes	rmed? 2 ☐ No		completion of cause of 2 No
Vit;		o Be	25. Was case referred to medical examiner? 1 [XYes 2 □ No	Hospital:		5D/0		Other			Check only o			
of	g Physer this serat di		27. Manner of Death		Inpatient 2 X of Injury th, Day Year)	28b. Time of		. Injury : Work?	4 U Nur		d. Describe l		6 □Other (Spectron) y occurred	cify)
sion	Attending Price death. ector: After by the funer.	atlo	1 Natural 5 Pending investigatio	n 10-	14-04	1400	₽ M	1 🗆 Y		10 DS	RIVER O	fuda	COLUM	O WITH PICKUP
Division	E Sign	Certification:	3 Suicide 6 Could not be determined	e 28e. Place build	of Injury - AI ho ing, etc. (Specify	ome, farm, str	eet, factory, o	ffice			City or Tov	m. State)	iral Route Number,
	To the Hospitel or Attend within 24 hours after death. To the Funerel Director: A completely filled in by the fi		29a. Certifier 1 Certifying Pt	vsician: To the	POD DI		occurred at	the time	date and					PELDUDRE
	To the Hospitel within 24 hours a To the Funeral I completely filled	edical	(Check only 2 Medical Examone)	niner: On the b	asis of examina ner stated.	tion and/or in	estigation, in	my opi	nion, deatl	h occurred	at the time.	date and	place, and due	to the cause(s)
	To the within 2 To the complet	N	29b. Signature and title of certifier	4	111.0	10			number M.E				e signed (Monti	h, Day, Year) 2004
			Mulimie	The	Still	IW)							-10	
<u>+</u>	1.10+1		30. Name and address of person who	. KOR	ELC.	111 Per		eet,	Bal	timor	e, Mai	yla	nd 2120	1
•	Sta Registr		31. Date filed (Month, Day, Year) OCT 1 8	2004	gistrar's Signa	ture	parti							

			State of Maryland / Department of Health and State of Maryland / Department of Health and Certificate of Death	Mental Hy	giene Reg.	004	34309
			Decedent's Name (First, Middle, Last)	2. Date of De			3. Time of Death
	Physicia /Medic		Toya Brown	Octobe			5:45 a M
)	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea	ith	4c.	. County of Dea	th
			Manor Care- Silver Spring Silver Spring 5 Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hr.			Montgom	
	Funeral Director		409-38-2320 1□ M 2⊠ F 92 Yrs. Months Days Hours Mir		ay, Year)	12 R	thplace (State or Foreign cuntry) LUSSIA
	yland		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	a-fa	cto	Maryland Prince George's Beltsville		_		1 ☐ Yes 2 ☑ No
	or 28	Directo	10e. Street and Number 10f. Zip Code		10g. Citi	izen of What Co	ountry?
	ath w		3598 Powder Mill Road 20705			SA	
136	d within 72 hours after death with the Maryland Jiene. I the Medical Examiner must be notified at the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue) 14. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue) 15. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue) 16. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue) 17. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue) 18. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue)	Specify Yes or Norto Rican, etc.)	0-	14. Race - Ame Black, Whit Specify Whi	e, etc.
215-0036	"natura	leted	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work forms to the life. DO NOT use retired)	orking	16b. Ki	ind of Business	/Industry
	ed within giene. ar than ",	Completed	College (1-4or 5+) College (1-4or 5+) Registered Nurse			ealth C	are
Maryland 21	be filed htal Hygi ad othar avant, t	Be (ame (First, Middle		Sumame)	
<u> </u>	Men narke	٩		na Daber			71-0-4-1
Mai	12 sh h and 7 is m traum		19a. Informant's Name/Relationship (<i>Type, Print</i>) Alan Brown/ Son 3598 Powder Mill Road		-		J.
	is 1 and 2 of Health a itam 27 is other train		20a Method of Disposition 20b Place of Disposition (Name of	Date		ocation - City or	
Baltimore,	permit. Pages 1 and 2 should be file Department of Health and Mental H Important: If itam 27 is marked oth any injury goother traumatic avan <u>once.</u>		`4 □Donation 5 □Other (Specify) Park	ober 15 2004	Rock	kville,	Maryland
Ba	permit Depar Impor any in	i V	21. Signature Tyneral Service Licensee Cle Francis J. Collin 500 University B1			me Inc. r Sprin	g, MD 20901
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.	ac or respiratory a	arrest,		Approximate Interval Between Onset and Death
)	Pnysician /Medical-	i ly	Immediate Cause (Final disease or condition resulting in death) a. Bilateral Ineumonia				0.100, 0.10 000,
	Examiner		Due to (or as a consequence of): Urosepsis				
	B #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause. Enter Underlying cause (Cispase or injury Cause (Cispase				
	ecuter and trans	Examiner	Causa (Cleurae or itilus) that initiated events resulting in death) Last Due to (or as a consequence of):				
68760,	ficate be executed g physician and as the burial-transit	edical Ex	Alzheimer's Dementia				
	± 00 m		IF FEMALE:				
.O. Box	at the death certifi by the attending I tached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 1 1 1 1 1 1 1 1 1			23d. Date of de Month	livery Day Year
۵.	res that tigned by	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did	tobacco u		the cause of death?
ecords,	w require been si should b			1 🗆	Yes 21	□No 3□Pi	robably 4 Stunknown
Reco	The farate has	Completed		24a. Was auto perf 1 🗆 Yes	psy ormed?	prior to death?	utopsy findings available completion of cause of
/ita	cian: sertific ector,	Be	examiner?	eath (Check only			
of	Physi this c	T.		Home 5 ☐ Res 28d. Describe			cify)
O	ding Ph h. After th funeral	tlon	27. Manner of Death 1 St Natural 5 Pending 2 Accident investigation 28a. Date of Injury 28b. Time of Injury 4 Work? 1 St Natural 5 Pending investigation 28b. Time of Injury 4 Work? 1 Yes 2 No	202. 2000.120		, 55551154	
Division of Vital R	or Attending Physician: after death. Director: After this certifici in by the funeral director.	Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location City or To			ural Route Number,
_	To the Hospital or Atternation 24 hours after de To the Funeral Director completely filled in by the	edical Ce	29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.				
	thin 2 the 1 the 1 mplet	Med	one) and manner stated. 29b. Signature and title of certifier / 29c. License number		29d. Dat	te signed (Mont	h, Day, Year)
	F ≥ F 8		Luti Vohra MD D20274		0c	tober l	1, 2004
	to se		30. Name and address of person who completed cause of death (Item 23a) (Type.Print) Kirti Vohra, M.D. 7710 Bradley Blvd, Bethesda, MD	20817			
186	Sta Regist		31. Date filed (Month, Day, Year) OCT 14 2004 32. Registrar's Signature Aparks				

			1 - For State Registrar	State of	of Marylar	nd / Depa <i>Cei</i>	artment of lartificate of	Health a	and Mental I	lygie		343	10
	زيون		1. Decedent's Name (First, Middle,	Last)					2. Date of	Death		3. Time of	Death
П	Physici /Media		MARTHA LY	NNE	BRA	SHEARS			Month OCTC		13 2004	9.25	a ^M
}	Examir		4a. Fecility Name (If not institution,	-			4b. City, Town,				c. County of Deat		
			Frederick Me				Frede				Freder		
	Funeral Director		5. Social Security Number 218-34-3705	6. Sex 1 ☐ M 24☐ F	7. Age (In yrs.	Yrs.	If Under 1 Year Months Days		Min. 8. Date of Month, NOV	Day Yea	$^{(r)}$ 1937 $^{(r)}$	hplace (State o PA	r Foreign
	pug *		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	cation					10d. Inside Ci	ity Limite
	Manyle f sho	ō		erick	1	•	fferson	n				XXYes	
	r 28a	Director	10e. Street and Number				10f. Zip Code			10g. C	Citizen of What Co	ountry?	
	th with	aiD	2627 Jeffer	son Pik	e		21	L755			USA		
	r dea	Funeral	11. Marital Status	Armed F		J.S. 13.	Was Decedent of f Yes, specify Cut	Hispanic Ori can, Mexicar	gin? (Specify Yes or i, Puerto Rican, etc.)	No-	14. Race - Ame Black, White		
36	s afte	by Fi	1 Never Married 3 Marrie 3 Widowed 4 Divorced	nd 1 □ Yes If Yes, Gi Year or D	No Notes:		1 ☐ Yes 2 ½ No	Specify:			Specify: Wh	ite	
9	2 hours	ted	15. Decedent's	s Education			dent's Usual Occu			16b.	Kind of Business/	Industry	
215	thin 7: e. en "n	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College ((Give	kind of work done DO NOT use retire	during mos ad)	t of working			ŕ	
7	ed wil	Son	10		,	co	ok	,				store	
Maryland 21215-0036	be fill Had Had off	Be	17. Father's Name (First, Middle, L Martin	L. Fox					er's Name (First, Mid garet E.				
ž	hould d Mer mark	2	19a. Informant's Name/Relationsh			19h Mailir	na Address (Stree	1	er or Rural Route Nu			in Code)	
ĭ	alth an alth an 27 ia		Carroll Brash		lusband	1)2627	Jeffe	cson	Pike, Je	ffe	cson, M	D 217	755
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Itams 23e or 28e-f show any injury or other traumatic event, the Modical Examinat must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation		State	cemetery, crer	sition (Name of natory or other pla		Date t10/18/0		Location - City or		
altir	mit. Pa bartmer portant / injury		' 4 □ Dopation 5 □ Other (Sp 21. Signature Function Service	14 -	1 70				ompson H				
ä	Per in De		yand)	I want		3	1 E. Ma	in S	t., Midd	leto	own, MD	e 21769	,
		\	234. Part 1. Enter the disease, or of sheek, or heart failure. List of Immediate Cause (Final	nly one cause on	each line.					y arrest,		Approximate Interval Bety Onset and D	ween
}	Physician /Medical		disease or condition resulting in death)		(or as a conse		EAST G	ANCE	<u> </u>			13 YEA	425
	Examiner	L			(0) 43 2 00//360	qualico di).							
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(or as a conse	quence of):							
	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Duata	(or as a consec								
8760,	be ex ician burial		, , , , , , , , , , , , , , , , , , ,	Due to	(or as a consec	quence or):							
687	phys phys s the	edical		d									
Вох (leath certific attending pl	n/Me	IF FEMALE: 23b. Was decedent pregnant		tcome of pregn		1				23d. Date of deli	very	
	death	Physician/Me	in the past 12 months? 1 □ Yes 2 ☑ No		birth 2 Teta nant at time of a		Ectopic pregnand Other (specify) _	ÿ		- 9	Month	Day Y	ear ear
<u>О</u>	that the de ed by the a detached f	Phys	9 Unknown										
	es Ded	by	Part II. Other significant condition	is contributing to d	leath but not re	suiting in the ui	nderlying cause gi	ven in Part I.			use contribute to 2√2No 3 □ Pro	the cause of de obably 4 □U	
Vital Records,	w requir been si should	Completed	-						24a. W	-		topsy findings a	availabla
Be	ysician: The lav is certificate has director, page 2	dmo							au pe	itopsy erformed?	prior to death?	ompletion of ca	luse of
a		a	25. Was case referred to medical					26. Place	of Death (Check on		lo 1 Ll Yes	2□ No	
	Physici this cer al direc	To B	examiner? 1 ☐ Yes 2 No	Hospital:	Inpatient 2	ER/Outpatien	t 3 DOA Ot	her	rsing Home 5□R		6 Other (Spec	eify)	
0	ding Ph h. After th funeral		27. Manner of Death 1 ✓ Natural 5 ☐ Pending	28a. Date (Mon	of Injury oth, Day Year)	28b. Time of Injury	28c. Inju Wo	ry at	28d. Descri	e how inj	ury occurred		
sio	tandi leath. tor: A the fu	cati	2 Accident investigation in Suicide 6 Could not	ation at he]Yes 2□		(0)			
Division of	al or At s after of I Direct d in by	Certification:	4 Homicide determin	and 286. Place	e of Injury - At h ling, etc. <i>(Speci</i>	nome, farm, str ify)	eet, factory, office		28f. Locatio City or	n (Street a Town, Sta	and Number or Ru te)	ral Route Numt	oer,
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier 17 Sertifying (Check only one) 2 Medical E	xaminer: On the b	e best of my kno pasis of examina oner stated.	ation and/or inv	estigation, in my	opinion, dea	d place, and due to t th occurred at the tim	ie, date ar	nd place, and due	to the cause(s)	
	To the Vithin 2 To the Complet	ž	29b. Signature and title of certifier	960	1 .		29c. Licen	se number		29d. D	ate signed (Month	Dey, Year)	
)			> Brosell	Com	1 CM	3	D	5176	5/	(0/14/6	9	
	10		30. Name and address of person w	no completed cau		m 23a) (Type, 501 C	Print) V. SEVEA	TH S	61 PT. FRA	SER	ICK M	0 217	0/
3	Sta Registi		31. Date filed (Month, Day, Year)		Registrar's Sign	ature 4	lon	No.					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Co		
State of Maryland / Department of Health and Menta	I Hygiene o I	
Cartificate of Death	_ Z U U 4	-

			1 - State Registrar		,	Certific	ate of	Death	h	R	20	04 3	3431	1
			1. Decedent's Name (First, Middle, L.	ast)						. Date of Dear		V	3. Time of	Death
	Physici /Medic		Christy Baldassar	i					C	october	10,	2004	10:25	Рм
	Examin		4a. Facility Name (If not institution, gi	ve street and number)		4b. C	ity, Town, o	or Location	of Death		4c. (County of Death		
		•	Stella Maris				monium	n			Ва	ltimore		
	Funeral		5. Social Security Number 112-09-1370	Sex. 7. Age (142-M 2□F 97	'In yrs. last b	Yrs. Mont	hs Days	Hours	Min. M	Date of Birth Month Pay ay 26,	Year	9. Birthp	place (State o	r Foreign
	Director		Usual Residence of Decedent						I I	ay 20,		/ New	York	
	yland		10a. State 10b. County	1	0c. City, Tov	wn or Location						1	Od. Inside Cit	ty Limits
	r 28a-f show	tor	Maryland Anne Aru	indel A	nnapo1	is							1 ☐ Yes	2. X No
	ith the	lre	10e. Street and Number				Zip Code			1	0g. Citiz	en of What Cour	ntry?	
	death with the Maryland ms 23a or 28a-f show	Funeral Director	209 Autumn Chase	Drive			21401				Unit	ed State	es	
		nue	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	13. Was De If Yes, s	specify Cub	Hispanic O an, Mexica	rigin? (Specit an, Puerto Ric	fy Yes or No- can, etc.)	1.	4. Race - Americ Black, White,		
36	hours after tural', or ite	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 XX No If Yes, Give			s ŽX No				3	Specify: Whi		
Ş	72 hours "natural"		15. Decedent's 8	Year or Dates:	16:	a. Decedent's L	Isual Occur	nation			16h Kin	d of Business/Inc	dustri	
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Maryland 21215-0036	2 sho and is m		19a. Informant's Name/Relationship									Town, State, Zip		
	bs 1 and 2 should b of Health and Ment i item 27 is marked r other traumatic e		Myrna Gibson / Da	ughter		209 Auti		nase				s, Mary		1401
0	ges 1 t of H If ite or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	Removal from State	cemete	of Disposition (i ery, crematory (or other pla		Dat			ation - City or To		
Baltimore,	t. Pa rtmen rtant:		`4 □Donation 5 □ Other (Spec		Lak e mo							sonville		
Bal	permit. Pages i Department of h Important: If ite any Injury or ot		21. Signature of Funeral Service Lice	nse			and Addre					or Fune napolis		
			23a. Part1. Enter the disease, or cor	molications that caused th	e death Do							Maporis	Approximate	
	DI		23a. Part1. Enter the disease, or cor shock, or heart failure. List onl Immediate Cause (Final	y one cause on each line.	2600	V452	2 30	_	2-3 %		001,		Interval Bety Onset and D	ween
	Physician /Medical		disease or condition resulting in death)	a Due to (or as a d										
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×	entific ding p		IF FEMALE:	23c If was outcome of	progpagou									
Bo	atten for us	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1☐Live birth 2 4☐Pregnant at tir	Fetal deat	h 3 □Ectopio 5 □ Other	c pregnancy	у			23	3d. Date of delive Month	_	'ear
P.O.	that the death ce ned by the attendi	Physician	1 ☐ Yes 2 X No 9 ☐ Unknown	9□ Unknown	ne or death	3 🗆 Other	(spacify) _							
	The law requires that the death c te has been signed by the attenc age 2 should be detached for us	by Ph	Part II. Other agnificant conditions	contributing to death but	not resulting	in the underlyin	ig cause giv	en in Part	11.	23e. Did tob	oacco us	e contribute to th	e cause of de	eath?
rds	quires in sign	q pe								1 □ Ye	s 2 🗆	No 3 ☐ Prob	ably 4 🛣 U	nknown
00	law requir as been si 2 should I	olete	Es 25 2/ 13.	11/97	1050	1-14-21.)			24a. Was a	n	24b. Were autor	psy findings a	available
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† \	S 0 5	To B	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 Inpatient	2 🗆 ER/O	utpatient 3	DOA Oth					□Other (Specify	()	
n of			27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	'ear) 28b.	Time of Injury	28c. Injur Wor			d. Describe ho				
Sio	Attanding r death. actor: Afterby the fune	catle	2 Accident investigation	1		М		Yes 2	□No					
Division	or Att after d Diract in by	Certification:	3 Suicide 6 Could not 4 Homicide determine		r - At home, f (<i>Specify)</i>	arm, street, fac	tory, office		28f	Location (St. City or Town	reet and I, State)	Number or Rura	I Route Numb	er,
	To the Hospital or Attanowithin 24 hours after death To the Funaral Diractor:	Ce	29a. Certifier 1 T Certifying P	Physiology T- the house	man lem mit in it					4.4				
	Hos 24 ho Fun	ledical	(Check only 2 Medical Exa	hysician: To the best of a iminer: On the basis of each and manner state	kamination a	ge, death occum nd/or investigat	ion, in my c	me, date a pinion, de	ath occurred	d due to the ca at the time, da	ause(s) a ate and p	ind manner as sta place, and due to	ated. the cause(s)	
	within 2 To the comple	Me	29b. Signature and title of certifier	did mainer state	u.		iseens الم	e number		29	9d. Date	signed (Month, I	Day, Year)	
	► ≤ ⊢ ō		1	1011	- (-)		-	15	504			11.8		
			30. Name and address of person who	completed cause of dea	th (Item 23a)	(Type, Print)								
			DR. EDDIE NAKH	UDA 2300 DI	JLANEY	VALLEY	RD.	TIMO	ONIUM.	MD 210	93			
	Sta		31. Date filed (Month, Day, Year)	32. R (strar's	s Signature	1 las	1.							
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State of Maryland / Department of Health and Mental Hygiene Reg. 2.004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Alonzo Bennett 12 7:20 M 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HEART HUSPITAL SACRED CUMBERLAND ALLEGANV If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 07/15/1924 6. Sex 1 M 2 ☐ F 9. Birthplace (State or Foreign Country) Mary land 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Director 220-16-6666 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the McCloal Examiner must be notified at Cumberland MD Allegany 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 21502 USA or itams 23a 211 Holland Street death v by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White "natural", 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) 12 Transfer Storage Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Theoda Collins Bennett Frank 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 is m any injury or other traum 810 MacDonald Terrace, Cumberland, MD Richard Bennett/ son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 □ Burial 2 ☑ Cremation 3 □ Removal from State 5 Other (Specify) 4 ☐ Donation Cumberland Crematory 10/15/2004 Cumberland, MD 21. Signatur Fun ral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARDIAC **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner use as the burial-transit certificate be executed attending physicien Box 68760 Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) P.O. the a signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ ulm Rde Mary 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has a Ince 1 ☐ Yes 2 ☐ No 1 Yes 2. No Hospital or Attending Physician: 25. Vas case referred / medical examiner? 26. Place of Death Check onl one Hospital: 1 Inpatient Other: 2 1 Tyes 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; After t 1 XNatural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 the 29c. License number 29d. Date signed (Month, Day, Year) 0 October 14, 2004 D13601 5 U 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) n bs 925 BISHOP ALSH ROAD CUMBERLAND ML. 21502 VICTOR relipa 31. Date filed (Month, Day, Year)
OCT 1 4 2004 32 Registrar's Signature State Registrar

Amend Items 23a, PtI, II, 25, 27, 28a, Tper MF, C836, 10/28/04dhb2 014 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 20, 2004 **Physician** Robert Cunningham August 8:36 p M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Clinton

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

The Days | Hours | Min. | Inn. Southern Maryland Hospital Prince Georges 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1∰M 2□ F 63 Yrs Director 579-50-1442 T941 Washington, DC Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "naturel", or items 23s or 28e-f show the Medical Executive roust be notified at 1 1 Yes 2 □ No Maryland Prince Georges Fort Washington Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20744 6801 Bock Road United States America death 1 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: Black Specify: þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Printer Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be filment of Health and Mental Hent: If item 27 is marked other Arthur Cunningham Helen Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Frye/Friend 5803 Marlboro Pike, District Heights, MD 20743 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 5 1 ☑ Burial 2 ☐ Eremation 3 ☐ Removal from State permit. Page Department of Importent: if any injury or once. 8/28/2004 Brentwood, Maryland Fort Lincoln Cem. * 4 □ Donation /5 1 Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Road Brentwood, Maryland 20722 21. Sig Fun ral Service Licenses /vom 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset_jand Death Subdural Hematoma Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Cura Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) burial-transit POLE OF MEDICAL EXAMINER Cevesal attending physician and for use as the burial-trar certificate be execu resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnance 5 Other (specify) in the past 12 months? Month Day 4☐Pregnant at time of death the t 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ Rinal disian End Stay 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Triknown peen: Subarachnoid hemorrhage; Sepsis 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 2 100 1 Yes 2 No 1 Yes or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes - 2 16 P 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending after death. Director: Af investigation 1 ☐ Yes XXNo 08/17/2004 Unknown Subject fell 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Clinton, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Southern Maryland Hospital Hospital the Hospitei within 24 hours a 1 • Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year) Rointan Farahitan D43446 Mn Georgia Ave Sit 3-41 silverspring 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 20902 ROINTAN FARAHIFAR 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 2001; 1. Decedent's Name (First, Middle, Last) October 14, 2004 **Physician** 9:50 A Rebecca K. Cornelison /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Beverly Healthcare Frederick Frederick 9. Birthplace (State or Foreign Country) Pennsylvania If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 6 Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min 1 ☐ M 2 🕏 F 209-42-7505 101 Director May 21, 1903 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County or than "natural", or Items 23a or 28a-f show the Medical Examinat must be notified at 1 ☐ Yes 2/☐ No Funeral Director Point of Rocks Maryland Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 1602 Gibbons Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: Be Completed by White 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home ages 1 and 2 should be filed on of Health and Mental Hygient: If item 27 Is marked other by or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Wilhelmina Ludwig George B. Cornelison 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1602 Gibbons Rd., Point of Rocks, MD 21777 Harold Cornelison / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important; if itel
any injury or otl 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 10-15-04 Frederick, Maryland Frederick Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home ourmen 1621 Opossumtown Pike, Frederick, MD 21702 ar 3a. Part 1. Enter the use se, or complications trat crused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st. 1, or heart failure. List only one caus an each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) engestive **Physician** 1105 /Medical Due to (or as a nsequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burial-Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year ò in the past 12 months?
1 Yes 2 No Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Ś Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 Yes 2 No certificate 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes XNo this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Certification: 5 Pending investigation 1 Natural within 24 hours are.
To the Funeral Director: An 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide 20 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier (Check only one) and manner stated To the 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 1016675 ares 30. Name and address of person who complet cause of death (Item 23a) (Type Print) Nicher KRUNSLICK 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 18 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg 6.0 0 4 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Rivelino Lee Crayton 10 /Medical 20044a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1**X** M 2□ F Director 14 43 unk. October 6,2004 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location Show 10d. Inside City Limits **Funeral Director** 1 ☐ Yes 2 No MD Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3705 Chevy Chase Lake Drive Apt. 3 20815 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed withIn 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married American India 1 ☐ Yes 2 ☒ No Specify: Be Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced White, Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 0 Infant Infant other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) is marked of Russell Lee Crayton Vivian Quirk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a Vivian Crayton, Mother 3705 Chevy Chase Lake Dr, #3, Chevy Chase, MD 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of the Important: If ite any injury or of once. 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 10/15/2004 Brentwood, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Enter the disease, or complications that ceused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) K٤ 13hr Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of Completed by Physician/Medical 23d. Date of delivery Month Day ven in Part I.

Physician /Medical Examiner

Maryland 21215-0036

Be Certification; To

After thi

nours after death.

neral Director: A
filled in by the fu

within 24 hours a

To the Funeral I

completely filled

Medical

State

Registrar

death.

Division of Vital Records, P.O. Box 68760

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnand 5 ☐ Other (specify)
---	--	---

1 Inpatient

28a. Date of Injury (Month, Day Year)

	23e. Did tobacco	use cor	tribute to	the cau	se of death?
	1 ☐ Yes	2 🗆 No	3□ Pro	babiy	4 X Unknow
	24a. Was an autopsy performed?		Were autoprior to codeath?		ndings availab on of cause of
th (C	heck only one)		-		
ome	5 🗆 Residence	6 □Ot	her (Speci	fy)	
28d	. Describe how inj	ury occu	rred		
28f.	Location (Street a City or Town, Sta	and Num te)	ber or Run	al Rout	e Number,

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

26. Place of Dea Other: 4 Nursing H

1 ☐ Yes 2 ☐ No

61585

29b. Signature and title of certifier

14

5 Pending investigation

6 Could not be determined

29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2004

<u>Heather E. Cahan, M.D.</u> 31. Date filed (Month, Day, Year)

25. Was case referred to medical exeminer?

1 ☐ Yes 2 No

27. Manner of Death

2 Accident

3 Suicide

4 Homicide

1 Natural

32. Registrar's Signature

9901 Medical Center Drive; Rockville, MD 20850

2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

		•	For State Registrer	State of M	aryland ,		artment of H tificate of L		d Mental Hyg	giene 200 L	343	16
	Physici	an	1. Decedent's Name (First, Middle, Li	Peggy	Ann C	urfm	an		2. Date of Dea Month	Day Ye	3. Time o	f Death 4 P M
>	/Medic Examin		4a. Facility Name (If not institution, gi Saint Joseph	ve street and number)			4b. City, Town, or		OCTOBER	4c. County of I		
	Funeral Director		214/28/5390	Sex 7. As	73	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 h Hours N	Hrs. 8. Date of Birth Nonth, Day June 6	, 1931	Birthplace (State of Country) Marylan	or Foreign d
	yland		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation				10d. Inside C	
	Ba-f si	Director	MD Washin	gton			Smith	sburg		10-02:		2/No
	3a or 2	I Dir	10e. Street and Number 212 W. Water	St.			10f. Zip Code 2 1 7	83		10g. Citizen of Wha		
	death	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S.	13.	Vas Decedent of Hi	spanic Origin?	(Specify Yes or No- uerto Rican, etc.)		American Indian, White, etc.	
920	s 1 and 2 should be filed within 72 hours after death with the Maryland (Health and Mental Hygiene. item 27 is marked other then "naturel", or Items 23a or 28a-f show other treumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 【XMarried 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No	1		Specify:	2010 1110211, 0101,	Specify:	White	
21215-0036	72 ho	Completed	15. Decedent's 8 (Specify only highest g		1	(Give	lent's Usual Occupa	luring most of	working	16b. Kind of Busin	ess/Industry	
121	e filed within al Hygiene. cother then "	ошр	Elementary/Secondary (0-12)	College (1-4or	5+)		00 NOT use retired, House W			Homem	aker	
g	be filed ital Hygi od other event, I	Be C	17. Father's Name (First, Middle, Las	t)			110000		Name (First, Middle,		431-0-1	- 1
Maryland	2 should be and Mental is marked eumatic ev	P	Earl McCarty 19a. Informant's Name/Relationship			10h Mailir	a Address (Street a		rence Ca		to Zin Code)	
	nd 2 sl lith an 27 is r r treur		James E. Curf								, , , , ,	
Baltimore,			20a. Method of Disposition 1 □ Burial 2 🏋 Cremation 3		20b. Place	e of Dispo	sition (Name of natory or other place			20c. Location - Cit		
ţ	t. Pa rtmer rtent: rjury		4 □ Donation 5 □ Other (Spec	ify)	Smit		rg Crem	The same of the sa	10/26	Smithsb	urg, MD	
Bal	permi Depar Impo any ir		21. Signature of Funeral Service Lice	ansee A S	MALH		. Name and Addres		J.L. Da	vis Fun	eral Ho	me 783
	9.		29a Part Enter the disease, or con shock, or heart failure. List only	nplications that cause y one cause on each t	d the death. I	Do not ent	er the mode of dying	g, such as card	diac or respiratory ari	est,	Interval Bet	te tween
	Pnysician		Immediate Cause (Final disease or condition			RTER	Y DISEAS	ΞE			Onset and YEARS	
	/Medical Examiner		resulting in death)	Due to (or as	a consequen	nce of):						
		ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequen	nce of):						
	be executed ician and burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c	a consequen	rce of):						
8760,	icate be executed physician and s the burial-transit	icalE		d	2 30110042011							
9	eath certifica attending ph	/Med	IF FEMALE:	23c. If yes, outcome	of pregnancy	v				22d Date of	deliver	
.O. Box	the d y the iched	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🖾 No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal de	ath 3	Ectopic pregnancy Other (specify)			23d. Date of Month		Year
s, P	es the gned be de	by Pl	Part II. Other significant conditions	contributing to death I	out not resultin	ng in the u	nderlying cause give	en in Part I.		bacco use contribu		
ord	w requir been si should	eted	ANEMIA END-STAGE REN	AL DISEASE					_ 1□Y			Unknown
Vital Records,	he lar e has age 2	Completed							_ 24a. Was a autop: perfor	sy prior mad? deat	e autopsy findings ' to completion of c h? Yes 2	available ause of
/ital		Be C	25. Was case referred to medical examiner?						Death (Check only or			
of/	Phys rthis ral di	- To	1 ☐ Yes 2X No 27. Manner of Death	Hospital: 1 🔀 Inpati		VOutpatier 3b. Time of	28c. Injury	at	g Home 5 Resid	ence 6 Other (Specify)	
	Attending I r death. ector: After by the funer	atlon	1 XNatural 5 ☐ Pending 2 ☐ Accident investigate	(Month, Da	iy Year)	Injury	Work	(? /es 2 □No		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
Division	Dir Oir	Certification:	3 Suicide 6 Could not 4 Homicide determine	d 286. Place of in	jury - At home tc. (Specify)	e, farm, str	eet, factory, office		28f. Location (S City or Tow	treet and Number on, State)	r Rural Route Nun	nber,
	Hospite 4 hours Funerel	edical C		Physician: To the best aminer: On the basis of and manner s	of examination							5)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	11-1-	11 1	\	29c. License	number		9d. Date signed (N	-	- 4 -
•			H.J.	Helou,				7965	C	clober	24,2	004
			30. Name and address of person wh	completed cause of		3a) (Type, 6 Ø 1		RIVE.	TOWSON.	MARYLAN	D 21204	.
* .	Sta		31. Date filed (Month, Day, Year) OCT 2 8 2	32. Regist	rar's Signature				The second of the second secon	The state of the s	resers als Moods Tag"	
1	Regist	rar	061202	UU4 Zen	wa	D	Spork	/				

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEM #23aPII, 27&28a-f PER ME Certificate of Death Reg. No. 2. Date of Deeth DASHLGR FERUMY Dey 09:19 An **Physician** JAMES ALGRAD 7004 /Medical City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Name (If not institution, give street end number) Examiner 'A MediCAL CENTER ALTIMORE DALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yea. 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 1**X** M 2□ F July 13, 1921 Maryland Director 214-18-3509 Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County th end Mental Hygiene. ?7 is marked other than "natural", or frems 23s or 28s-4 show traumatic event, the Medical Examiner must be nothing at 1 ☐ Yes 2 No Funeral Director Maryland Cecil North East 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 411 Blackhill Road 21901 United States permit. Pages 1 end 2 should be filed within 72 hours effer deat Department of Health end Mental Hygiene. Important: if them 27 is marked other than "natural any injury or other trauments." 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 10 Yes 2 No 1942 to 17 Yes, Give Yeer or Dates: 1946 Race - American Indian, Black, White, etc. 11. Maritel Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: White Specify: Be Completed by 3K Widowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) Lineman Railroad 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Walter Dashler Ethel Knight 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) David B. Keithley/Son 103 Moyer Drive, Aberdeen, Maryland 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date February 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Havre de Grace, 4 ☐ Donation 15 ☐ Other (Specify) Angel Hill Cemetery 24, 2004 Maryland 21. Signature of Funeral Service Ricens 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland 21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Ceuse (Final disease or condition resulting in death) 2 DA75 RAUTENZEMIA Examiner Due to (or as a consequence of): Examiner Tupoindo PHUGALTES ONE WEEK attending physician end for use es the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical SWAPPROVED BY MEDICAL EXAMINER Due to (or as e consequence of): use given in Part I. Part II. Other significant conditions contributing to death but not resulting in the undertailed 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? FRETUNGO LEFT Z 1 ☐ Yes 2 No 1 Ves 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: ppatient 2 ☐ ER/Outpetient 3 ☐ DOA YYes -Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 28b. Time of Injury 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28e. Date of Injury (Month, Dey Year) 1 Suicide 5 Pending investigation 1 ☐ Yes 2 → No FEB 06,2004 unk 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide OUTSIDE RESIDENCE 411 BLACKHILLRD. NORTH EAST, MD. 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date end piece, and due to the cause(s) and manner es steted. | Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

requires that the death certificate be executed ecords, been si The jaw ours efter death.

eral Director: After this certificatilled in by the funeral director, Physician: Division 6 within 24 hours e To the Funeral C

54-1

State

Registrar

30. Name end address of person who completed cause of death (Item 23e) (Type, Print) BEAMON IMD Charles 31. Date filed (Month, Day, Year)

(Check only one)

29b. Signature and little of certifier

FEB 2 4 2004



Beamon, m.n.)P

29c. License number

29d. Date signed (Month, Day, Yeer)

20

State of Maryland Department of Health and Mental Hygiene O O Las Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year **Physician** October 10, \mathbf{P}^{M} 2004 Donna Charles Dumire 1:13 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Hagerstown Washington County Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2**X** F 45 Director 5-31-1959 MD 220-80-1646 Usual Residence of Decedent Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinat must be redified at 1 Yes 2 □ No Director Williamsport MD Washington the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21795 US 124 S. Conococheague Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 Never Married 2 Married
3 Widowed 4 Divorced Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7, th and Mental Hygiene. 7 is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) Clerk Food Retail 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Barbara Louise Lanamore ပ Charles Robert Campbell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If item 27 is i ury or other trau 124 S. Conococheague Street, Williamsport, MD 21795 Jack E. Dumire/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department important: It any injury o Cedar Lawn Mem. Gdns. 10-14-2004 Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740 Bryan K. Kenworthy per dvr 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Exsanguination /Medical Due to (or as a consequence of): Examiner Splenic Rupture Sequentially list conditions, if any, leading to immediate cause. Enter Undern in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit requires that the death certificate be executed Acute Pancreatitis Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2□ No 1X Yes 2 🗌 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Xinpatient 2 1X Yes 2 □ No 2 ER/Outpatient 3 DOA Director: After this in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural To the Hospital or Attending 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier within 2 To the 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 29c. License number O.C.M.E. October 12, 2004 completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 na 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar OCT 2 6 2004

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registre Certificate of Death Reg. No. () 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** OCTOBER 18, 2004 9:30 a M Dalv Elizabeth /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's St. Mary's Hospital If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Feb. 23, 19 Leonardtown 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 M 2 F Yrs. 74 1930 Washington, Director 577-36-2739 DC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show "natural", or Items 23a or 28e-f shov adical Examiner must be notified at 1 Yes 2 No Directo Mechanicsville Maryland St. Mary's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20659 United States 42366 Allison Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ■ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 E No Specify. Specify: þ White 3 ₩ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked 2 Kinney Baxter Sarah Hawe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai Linda D. Barko / Daughter 988 John's Woods Road, Lusby, Maryland 20657 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 de Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Queen of Peace 10-21-2004 Helen, Maryland 21 Signature of the state of th 22. Name and Address of Facility Brinsfield Funeral Home, P.A. M00052 22955 Hollywood Road, Leonardtown, MD 20650-0279 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Metastoche Immediate Cause (Final Sm **Physician** week disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, If any leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to or as a consquence of attending physician and I for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4□Pregnant at time of death 5 Other (specify) signed by the a 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 No 1 Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After : 1 Natural 5 Pending investigation 1 Tes 2 No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D52815 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P.O. Box 527 Leonardtown, MD 20650 Dr. Alexander 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar OCT 2 0 2004

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

			For State Registrar	State of Marylar		artment of F rtificate of		F	Reg. No.	
	Physicia /Medic	al	1. Decedent's Name (First, Middle FRANK F	DOWLINI	4	4h Cib. Town	r Location of Deat	2. Date of Dea Month	Day	3. Time of Death
	Funeral Director		4a. Facility Name (If not institution UNIV. 07 MARYU 5. Social Security Number 215-28-1663 Usual Residence of Decedent 10a. State 10b. County	AND MEDICAL SY 6. Sex 1 MM 2 F 5 1		BALTI If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	. 8. Date of Birth	y, Year)	9. Birthplace (State or Foreign Country) MARYLAND 10d. Inside City Limits 14 Yes 2 \(\) No
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. If Health and Mental Hygiene. Itiem 27 Is marked other then "naturel", or Items 23a or 28a-f show other treumatic event, The Medical Exar. II act must be notified at	To Be Completed by Funeral Director	MD WICO 10e. Street and Number 34539 OLD OCEA 11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced (Specify only highest Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, FRANK A. DOWLT 19a. Informant's Name/Relations	N CITY ROAD 12. Was Decedent Ever in Unity of the Community of the Commun	16a. Dece (Give life.	E 10f. Zip Code 21850 Was Decedent of H If Yes, specify Cub: 1 Yes X No dent's Usual Occup, kind of work done DO NOT use retired	lispanic Origin? (S an, Mexican, Puer Specify: leation during most of wo 1) 18. Mother's Nai	specify Yes or No- to Rican, etc.) rking me (First, Middle,	Black, Specity: 16b. Kind of Busi CON Maiden Sumame, UCH	nat Country? - American Indian, , White, etc. WHITE iness/Industry ISTRUCTION
Baltimore, Ma	permit. Pages 1 and 2 s Department of Health an Importent: If item 27 Is eny injury or other treu QDC9.		FRANK A. DOWLIN 20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (S. 21. Signature of Funeral Service	S, SRFATHER 3 Removal from State CRitical State CRitical State CRitical State CRitical State CRitical State CRitical State CRitical State CRitical State CRitical State CRitical State CRitical State CRitical State CRitical State CRitical State CRitical State CRITICAL State CRItical State CRItical State CRItical State CRItical State CRItical State CRItical State CRItical State CRITICAL State CRITICAL State CRITICAL State CRITICAL State CRITICAL State CRITICAL State CRITICAL State CRITICAL State CRITICAL State CRITICAL State CRITICAL State	3453 Place of Disp cemetery, cre EMATORY	9 OLD OCE position (Name of matory or other plan 7 OF DELM. 2 Name and Addre. 705 E MAI	EAN CITY CO ARVA 10- SS of Facility IN STREET	ROAD PIT Date 14-2004 BOUNDS F SALISB	TSVILLE, 20c. Location - C DELMAR, UNERAL H URY, MD	MD 21850 Sity or Town, State DELAWARE IOME
68760,	American and wasician and the burial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to himrediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. END STHE Due to (or as a consect. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect.)	E UVE quence of):					Interval Between Onset and Death
P.O. Box 68	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	⊒Ectopic pregnanc □ Other (specify) _	,		23d. Date Mont	h Day Year
Records, F	law requires tha as been signed 2 should be de	Completed by P	Part II. Other significant condition	ins contributing to death but not re	-		en in Part I.	1 TY	res 2 No 3	oute to the cause of death? B Probably 4 Unknown ere autopsy findings available for to completion of cause of
of Vital	Attending Physicien: The law rdeath. sctor: After this certificate has by the funeral director, page 2 s	To Be	25. Was case referred to medica examiner? . 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendir investi	28a. Date of Injury (Month, Day Year) gation	ER/Outpatie	of 28c. Injur	ner: 4 ☐ Nursing h	ath <i>(Check only or</i>	21 No 1 [
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical Certification;	(Check only 2 Medical	g Physician: To the best of my kr Examiner: On the basis of examine	nowledge, dea	th occurred at the ti	me, date and place	City or Tow	rn, State) cause(s) and man	r or Rural Route Number, ner as stated. nd due to the cause(s)
	To the I	Medi		and manner stated. GJ05H, MD who completed cause of death (Ite			113	The state of the s	OCTOBEK	(Month, Day, Year)
	St Regist	ate rar	CRISHME JOSH 31. Date filed (Month, Day, Year, OCT 18	32. Rogistrar's Sign		EST. BO		-, MO, Z	1201	

OK US IS PET ME

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Oct. 2004 Mary Catherine Dysert 21 08:40 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Homewood at Williamsport Williamsport Washington If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 🕱 F 218-30-9436 88 Director 02/16/1916 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is markad othar than "natural", or Itams 23a or 28a-f show traumatic evant, the Medical Examener must be notified at 1 Yes 2 No Director MD Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16505 Virginia Avenue 21795 US Funerai death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. Is markad other then "naturel", or Ital 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Unit Control Manager 12 Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Maurice E. Miller Florence M. Saylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a Judith D. Hawbecker, Daughter 13514 Paradise Dr., Hagerstown, MD 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State ö permit. Page Department of Important: If any injury or once. 4 ☐ Donation _ 5 ☐ Other (Specify) Smithsburg Cremator 10/22/2004 Smithsburg, MD 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Fuperal Service License 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. pproximate iterval Between inset and Death Immediate Cause (Final Physician TICCHILD disease or condition resulting in death) /Medical Due to (or as/a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine use as the burial-transit death certificata be exacuted Due to (or s a consequence of): ed by the attending physician detached for use as the burial Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Dav 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 sh autopsy performed? Yes 2 No 2□ No 1 🗌 Yes 1 Yes Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) funeral 27. Menner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Diractor: 6 Could not be determined 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide ō the Hospital within 24 hours e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signat 29d. Date signed (Month. Day, Year) 29c. License number lleDicox Materia o completed cause of death (Item 23a) (Type, Print) mi 31. Date filed (Month Day Yea 32. Registrar s Signature State Registrar

			State of Maryland / Dep 1- State of Maryland / Dep 23a per Dr., G836, 10	partment of Health and M 128 Oct he Princate of Death	ental Hygiene	101. 21.222			
	Physici /Medi		Decedent's Name (First, Middle, Last) GERALD LEE DWYER		2. Date of Death Month Day OCT 21	Year 2004 6:10 P M			
	Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death NATIONAL NAVAL MEDICAL CENTER 4c. County of Death MONTGOMERY						
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 498-30-8301 72 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9 / 23/1932	Birthplace (State or Foreign Country) Missouri			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menial Hygiene. Importent: If item 27 is marked other than "natural; or items 23a or 28e-f ahow any highly or other traumatic event, the Medical Evertiral must be notified at once.	ō	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L			10d. Inside City Limits			
		Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?						
Maryland 21215-0036		Completed by Funeral	3219 Locker Street 11. Marital Status 1 □ Never Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1.□ Yes 2 □ No M Yes, Give Year or Dates:	22042 Was Decedent of Hispanic Origin? (Spell Yes, specify Cuban, Mexican, Puerto F	Rican, etc.)	.A. Race - American Indian, Black, White, etc.			
			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) College (1·4or 5+)	edent's Usual Occupation e kind of work done during most of workir DO NOT use retired)	16b. Kind	of Business/Industry			
		To Be Co	17. Father's Name (First, Middle, Last) James Albert Dwver	18. Mother's Name	(First, Middle, Maiden Su	S. Navy _{Imame)}			
			Cora Byram Dwyer Wife 3219	ing Address (Street and Number or Rural Locker St. Falls	Route Number, City or T	own, State, Zip Code)			
Baltimore,			20a. Method of Disposition 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify) 20b. Place of Disposition cemetery, cre	Cemetery 10/30	,2004 Rapid	tion - City or Town, State			
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~	The law requires that the death certificate be executed with a standing physician and page 2 should be detached for use as the burial-transit		23a. Port 1. Enter the disease, or complications that gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death disease or condition RENAL FATLURE disease or condition a						
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of Vital	ding Phyaician: Th n. After this certificate funeral director, pag		25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\frac{1}{2} \text{No} \) Hospital: 1 \(\frac{1}{2} \) Inpatient 2 \(\text{ER/Outpaties} \)	Check onlone e 5 Residence 6 Other (Specify)					
Division o	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral		1 ♣Natural 5 Pending (Month, Day Year) Injury 2 ♣Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? M 1 Yes 2 No		28d. Describe how injury occurred			
Divi			4 Homicide determined 286. Place of injury - At nome, farm, st building, etc. (Specify)	building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		Medical	29a. Certifier (Check only one) 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
			29b. Signature and title of certifier	29c. License number 229179 (NY)	OCTOR	igned (Month, Day, Year) P 22, 2064			
	10		30. Name and address of person who completed cause of death (Item 23a) (Type SAM W. GAO LT MC USNR	IONAL NAVAL HESDA MD 208	MEBICAL CENTER				
	Sta Regist		31. Date filed (Month, Day, Year) OCT 2 8 2004 Service 4	land 1	7	,			

DHMH 17 Rev 1/2001

		State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. 200							21111h	34323
	Physicia		1. Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
П			Norma Jean	DiBe	enedetto			Month	9, 2004	9:00 ам
>	/Medic Examir		4a. Facility Name (If not institution, give	street and numbe	r)	4b. City, Town, or L	ocation of Death		4c. County of Dea	ath
	Kajiiii		9732 Glen Avenue	#103		Silver	Spring		Montgom	loru
	Funeral		5. Social Security Number 6. Se	x 7.7	Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Bi	rthplace (State or Foreign
	Director		578-40-4639]M 2⊠F	72 Yrs.	Months Days	Hours Min.	(Month, Day, Y Nov. 8,	ear) (ennessee
	should be filed within 72 hours after death with the Maryland Manal Hygiene. Mark Med other then "returel", or Items 23s or 28s-f show marked other then "returel", or Items 23s or 28s-f show matic avent, the Medical Examinar must be notified at	Director	Usual Residence of Decedent							
			10a. State 10b. County		10c. City, Town or Lo	ecation				10d. Inside City Limits
			Maryland Montgom	ery	Silver S	oring				1 ☐ Yes 2 🙀 No
			10e. Street and Number			10f. Zip Code		100	g. Citizen of What C	Country?
			9732 Glen Avenue,	#103		20910			USA	
	ams ams	Funerai	11. Marital Status	12. Was Deceder Armed Force		Was Decedent of Hisp If Yes, specify Cuban,	anic Origin? (Sp. Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
98	or It	by F	1 Never Married 2 Married	1 ☐ Yes 218 If Yes, Give		1 ☐ Yes 2 ☑ No	Specify:		Specify: W	·
ë	ural'	d b	3X Widowed 4 □ Divorced	Year or Dates						
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Maryland 21215-0036	d be antal	0 86							,	
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ō	ages ut of u		1 ☑ Burial 2 ☐ Cremation 3 ☐ I		cemetery, crei Gate	natory or other place) of Heaven	Oct	ober 13		
altimore,	ritme ritani		 4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service Licens 			metery	ef Equility			ing, Maryland
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١,			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	ne cause on each	line.	er the mode or dying,	such as cardiac	or respiratory arrest		Interval Between Onset and Death
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387	icate phys	dical		d						
×	eath certific attending p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ne of pregnancy				23d. Date of de	divory
Box	atter for L	Completed by Physician/Me	in the past 12 months?	1 Live birth	2 Fetal death 3	Ectopic pregnancy Other (specify)			Month	Day Year
o.	at the de by the a tached		1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						
۵.	ss tha		Part II. Other significant conditions co	ntributing to death	but not resulting in the u	nderlying cause given	in Part I.	23e. Did tobac	cco use contribute t	o the cause of death?
Records,			Diabetes Mellitus, Hypertension				2 ☑ No 3 ☐ Probably 4 ☐ Unknown			
000	w require been signal							24a. Was an	24h Wara a	utaney findings available
Ä	The law cate has page 2 s							autopsy	prior to	utopsy findings available completion of cause of
_			OF Man ages referred to medical					1 ☐ Yes 2 ☐		s 2 No
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Division of	after Dira Sin by	Certification:	4 Homicide determined	building,	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	spital ours a naral (29a. Certifier 12 Certifying Phy	sician: To the bes	st of my knowledge, deatl	occurred at the time.	date and place	and due to the caus	se(s) and manner a	s stated
	a Hospital 124 hours a a Funaral l letely filled	edical	(Check only 2 Medical Exami	ner: On the basis and manner:	of examination and/or in	vestigation, in my opin	ion, death occur	ed at the time, date	and place, and du	e to the cause(s)
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Me	29b. Signature and itle of certifier	/	,	29c. License n	umber	29d	. Date signed (Mon	th, Day, Year)
)			Valinda.	fr. Sa	zin	D135	548		October :	12, 2004
	16		30. Name and address of person who co			Print)				•
			Rajindra K. Sari		10801 Lock	·	#280	Silver	nning M	20003
	Sta	te.	31. Date filed (Month, Day, Year)	32. Regis	trar's Signature	0		PITAGE 2	brind' WI	7 20301
	Registr		OCT 14 20	04	ever B	sporks	/			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra 34324 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Year Marion Veronica Fenwick OCTOBER 2004 6:30 a /Medical 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death 4c. County of Death Examiner St. Mary's Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Months Days Hours Min. (Month, Day, Year) May 22,1913 Leonardtown St. Mary's 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🖫 F Maryland Director 578-22-3299 Usual Residence of Decedent the Maryland 10c. City Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show traumatic evant, the Medical Exercities is ust be notified at 1 ☐ Yes 2 ☑ No Director MARYLAND St. Mary's Chaptico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or itams 23a 22873 Pleasant Lane 20621 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after of Hygiene. ther than "natural", or ital 1 Never Married 2 Married ☐Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ◯ No Specify: à Specify: B1ack 3XXWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Practical Nurse Health Care ges 1 and 2 should be filed very filed to the filed balth and Mental Hygie is tram 27 is marked other the standard other the st 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Arthur Garfield Maddox Ann Rebecca Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa A. Saxon/Daughter 3007 Kingsway Road, Ft. Washington, MD 20744 othar t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of H
Important: If ital
any injury or ott 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart Cemetery Oct. 29,2004 Bushwood, Maryland 21. Signatify of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A., P. O. Box 270, Leonardtown, Maryland 20650 Part1. Enter the disease, or complications that caused the beath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -ntra Cerebral Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner troke Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ypertension burial-transit The law requires that the death certificate be executed Vital Records, P.O. Box 68760. attending physician Physician/Medical the IF FEMALE esn. 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ö Year Day 4☐Pregnant at time of death 5 Other (specify) signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? has certificate 2[No 1 ☐ Yes 2 No 1 Yes To the Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 Dipatient 2 ER/Outpatient 3 DOA Division of this 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of After t 28d. Describe how injury occurred Certification: Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: in by the 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) D55027 10-21-04 pleted cause of death (Item 23a) (Type, Print) Manoj D PANWALA SHAH ASSOC CHARLOTTE HALL MD. 32. Registrar's Signature State 5 Registrar

MARION VERONICA FENWICK

Amend item 11 per informant g840 2-22-05 vt
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#200,25,perFH_MD_C837,117904 TP

			for State Registrar	State of Maryla		ent of Health and I ate of Death	Mental Hygie Reg.	2004	34325		
			1. Decedent's Name (First, Middle, La	ist)	P 1-1	۲,	2. Date of Death Month	Day Year	3. Time of Death		
1	Physici /Medi		TATRICIA	Low J	TRAK LI	N	16	Day Year	900 AM		
1	Examir		4a. Fecility Name (If not institution, give	e street and number)	/ 4b. C	ity, Jown, or Location of Death		4c. County of Death	<i>i</i> 2		
			29730 5	cett Wil	d (1)	TR. ANNE		S: MRIST			
	Funeral			Sex 7 Age (In y	7 Yrs. Mont	der 1 Year If Under 24 Hrs. hs Days Hours Min.	8. Date of Birth	cour			
	Director		Usuel Residence of Decedent	3			6 7 7	MARKI	Strang 74:		
	yland		10a. State 10b. County		City Town or Location	1		1	Od. Inside City Limits		
	B-f e	to	Md SOMER	SEt	TR. ANN	E			10 16s 2 No		
	or 28	Oire	10e. Street and Number	//	BLVA 101.	Zip Code	10g.	Citizen of What Cour	ntry?		
	72 hours after death with the Maryland naturel', or items 23a or 28a-f ehow diral Examinet must be notified at	Funeral Director	29730	00000		21853		USA			
	er de	nue	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13. Was De	ecedent of Hispanic Origin? (S specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White,			
36	I', or	by F	1 ☐ Never Married 3 ☐ Widowed 4 ☑ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 🗆 Ye	s 2 No Specify:		Specify:	AMBLICAN		
5-0036	2 hou	ted	15. Decedent's E	ducation	16a. Decedent's U	Isual Occupation	166	o. Kind of Business/Inc			
215	within 7. ene. then "n	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	(Give kind of life. DO NO	work done during most of wor T use retired)		1/ 1	1 -		
7	filed withi Hygiene. ther ther	FO.	12	2	Vic	R MANAJE		-Home day	PET		
nd	tai Hyd oth	Be	17. Father's Name (First, Middle, Last		/	18. Mother's Nan	ne (First, Middle, Maid	den Sumame)			
Z	2 should be and Mental ie marked o aumatic eve	2	William	RED EN		2619	-ADEITI	STANLIN	}		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "naturel", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Helationship,		3 408	ess (Street and Number or All	Trans.	ty or Town, State, Zip	Tode)		
	t and thealth		20a. Method of Disposition		. Place of Disposition (Name of	Date 200	Location - City or To	own, State		
JO L	8 = 5		1 Deurial 2 Cremation 3 Donation 5 Other (Speci	Themoval hom State	Astronomy Crematory	or other place) 10/1	8/04	£1. 7	3		
Baltimore,		1	21. Signature of Euneral Service Lice		22 Name	and Address of Facility	3/12	479 Frike	s July nost		
ä	permit. Departr Imports eny inje	6	Smill	til	BIENA	lik Smith ;	2/H PO A	NAR MALY	LAND 21855		
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	pplications that caused the de					Approximate Interval Between		
5	Physician		Immediate Cause (Final disease or condition	1_1,4	Concer	(Adens ca	min m	~)	Onset and Death		
*	/Medical		resulting in death)	Due to (or as a cons		C process					
	Examiner		Sequentially list conditions,	b							
	ed isit	Examiner	if any, leading to initiodate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	lequerios ot):						
	xecul and al-trar	хап	that initiated events resulting in death) Last	c. Due to (or as a cons	equence of):						
8760,	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical		d							
9	g phy g phy as the	0		U.					MALON-		
Вох	leath certifie attending p	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pred 1□Live birth 2□F		c pregnancy		23d. Date of delive	ery		
	deat e att	sicia	in the past 12 months? 1 ☐ Yes 2☐ No	4□Pregnant at time of				Month	Day Year		
P.0	that the de ed by the a detached	Physician/M	9 Unknown								
	res tha signed be de	by	Part II. Other significant conditions	contributing to death but not i	resulting in the underlyin	g cause given in Part I.		co use contribute to the			
0.0	w require been sig should b	Completed		****				2 140 3 1100	ably 4201KHOWH		
3ec	has the	ld m					24a. Was an autopsy performed	prior to cor	psy findings available mpletion of cause of		
Vital Records,							1□ Yes 2□		2 No		
		o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	D50/0	Other	th (Check only one)	0.500			
of	Phys er this eral di	F	27. Manner of Death	1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year)		28c. Injury at	28d. Describe how in	6 □Other (Specify	Y)		
ion	Attending Firdeath. ctor: After by the funer	atlo	1 Hatural 5 Pending 2 Accident Investigation) Injury M	Work? 1 ☐ Yes 2 ☐ No					
Division	r Atte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, street, fac	tory, office	28f. Location (Street City or Town, St	t and Number or Rura	I Route Number,		
	ital or irs after ral Dire	Cer			236						
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely lilled in by the fu	ical	(Check only 2 Medical Exa	miner: On the basis of exam	rnowledge, death occuri ination and/or investigat	red at the time, date and place ion, in my opinion, death occu	, and due to the cause rred at the time, date	∍(s) and manner as st and place, and due to	tated. the cause(s)		
_	thin 2 the omplet	Med	29a. Certifier (Check only one) 29b. Signeture and title of certifier 29c. Certifier 29c. Certifier 29c. Certifier 29c. License number 29d. Date signed (Month, Day, Yea								
	₩ 3 F 8		62 Ck						**		
			30. Name and address of person who	completed cause of death ()		4005617		- / · (/ 59			
			Robert	A. Coter	218	H0056177	ST SALL	shy Ms	21801		
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sig							
	Registi	rar	OCT 14	2004	. K lan	10					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiere O O I.

			For State Registrar	State of M	aryland /	Cen	rtment of F tificate of	leaith and Mi <i>Death</i>		ier 2 0 0 4	34326
	o.		1. Decedent's Name (First, Middle, La	ast)					2. Date of Deat	h	3. Time of Death
	Physici /Medic		Cecelia Eleano	r Foglema	n				Month October	Day Ye 12, 2004	
	Examin		4a. Facility Name (If not institution, gir	ve street and number)			4b. City, Town, o	r Location of Death		4c. County of D	
			Arden Court Assi	sted Livin	σ		Silver	Spring		Montgon	10 1 7
	Funeral		5. Social Security Number 6.	Sex 7. Ag	e (In yrs. last t	oirthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	Veerl 9.	Birthplace (State or Foreign
	Director		165-16-1979	1 M 2 3 F	84	Yrs.	World's Days	Tiodis Mill.	8. Date of Birth (Month, Day, April 26	, 1920 P	Country) ennsylvania
	pu .		Usual Residence of Decedent 10a. State 10b. County		10c. City, To						
	anyla shov	_	10a. State 10b. County		10c. City, 10	wn or Loc	ation				10d. Inside City Limits
	8e-f	ecto	Maryland Montgo	omery	Silv	er S	pring				1 ☐ Yes 2 ☑ No
	ith th	Director	10e. Street and Number				10f. Zip Code		10	ng. Citizen of What	Country?
	ath v		13509 Creekside				20904			USA	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other than "natural, or Items 23a or 28e-f show any Injuryor other treumatic event, the Medical Exantment clust be notified at ones."	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 11 Yes, Give Year or Dates:			/as Decedent of H Yes, specify Cuba ☐ Yes 2 A No	ispanic Origin? (Spec in, Mexican, Puerto R Specify:	eity Yes or No- lican, etc.)	14. Race - A Black, W Specify: W	
5-0	72 h	etec	15. Decedent's E (Specify only highest gr		16	a. Decede	ent's Usual Occup	ation during most of workin	2	16b. Kind of Busine	ss/Industry
7	thin se.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. D	O NOT use retired	daring most or working	9		
7	ed wygien ygien ner th	Co	12			Sal	es			Retail	Clothing
n n	be fill d off	Be	17. Father's Name (First, Middle, Las.	t)				18. Mother's Name	(First, Middle, M	faiden Sumame)	
yla	ould Men arke	ို	Frank Smith					Esther	P. Sort	man	
Maryland	2 sh and Is m		19a. Informant's Name/Relationship	(Type, Print)	19	b. Mailing	Address (Street	and Number or Rural	Route Number,	City or Town, Stat	e, Zip Code)
≥	and ealth m 27 ner tr		Christopher Fog	leman/Son	1	3509	Creeksi	de Drive,	Silver	Spring,	MD 20904
ore	of H		20a. Method of Disposition 1 Burial 2 □ Cremation 3	Removal from State	20b. Place cemet	of Dispos ery, cremi	ition (Name of atory or other plac	Da		Oc. Location - City	
Ĕ	Pag nent ent: I		4 □ Donation 5 □ Other (Speci		Rest	irrec	tion	200		ontoursy:	ille, PA
Baltimore,	Departi Importi any Inj		21. Signature of Funeral Service Lice	Gle Cole		Fra 500	Name and Address ancis J. O Univer:	ss of Facility Collins F sity BLvd,	uneral W, Sil	Home Inc ver Spri	ng, MD 20901
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	polications that caused	the death. Do	not ente	r the mode of dyin	g, such as cardiac or	respiratory arre	st,	Approximate
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a Congest:		rt Fa					Interval Between Onset and Death
ы	4	<u>.</u>	Sequentially list conditions.	b. Critical			enosis				
	ed isit	Examiner	Sequentially list conditions if any, leading to immediate cause. End Uncertains Cause (Disease or injury		a consequence						
	eecut and I-trar	хап	that initiated events resulting in death) Last	c. Cellulit	is-bot		gs				
09	be e ician buria	alE		,		3 01).					
68760,	tificate be executed og physician and as the burial-transit	edical	and the same	d Hyperter	ision						
	ding se as		IF FEMALE:	23c If yes outcome	of pregnancy	- 171					
.O. Box	that the death cert ed by the attendin detached for use	by Physician/N	23b. Was decedent pregnant in the past 12 months? 1							23d. Date of a	delivery Day Year
S, D	The law requires that the ste has been signed by th page 2 should be detache	y P	Part II. Other significant conditions	contributing to death b	ut not resulting	in the und	dertying cause give	en in Part I.	23e. Did toba	acco use contribute	to the cause of death?
Ë	w requires to been signed should be contact.		Emphysema						1 🗆 Yes	2 No 3	Probably 4 ⊠Unknown
Record	s bec	Completed							24a. Was an	24b. Were	autopsy findings available
æ	The lav	E C							autopsy	ed? prior t	o completion of cause of ?
Vital		O	25. Was case referred to medical					26. Place of Death	1 Yes 2		es 2□No
>	S (2 =	0 0	examiner? 1 ☐ Yes 2 ☑No	Hospital:	nt 2 ER/C	lutnationt	3□ DOA Othe			/ ice 6 ⊠Other <i>(S)</i>	Toolated
0	ding Phy h. After this funeral c	\vdash	27. Manner of Death	28a. Date of Inju	y 28b.	Time of	28c. Injury	at 28		v injury occurred	
0	th. :: Afte	를	1 Natural 5 Pending 2 Accident investigation	(Month, Day	/ Year)	Injury	Work M 1 □ Y	(? Yes 2 □ No			Living Facility
Division of	or Attending after death. Director: After in by the funer	fica	3 ☐ Suicide 6 ☐ Could not b	1 286. Place of Init	ıry - At home, i	arm, stree	et, factory, office	28	f. Location (Stre	eet and Number or	Rural Route Number,
	al or s afte l Dir d in b	Certification;	4 Homicide	building, et	c. (Specity)				City or Town,	State)	
	To the Hospitel or Atten within 24 hours after deat To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Pl	nysician: To the best	of my knowledg	ge, death o	occurred at the tim	e, date and place, an	d due to the cau	use(s) and manner	as stated.
	ne Ho	edical	(Check only 2 Medical Examone)	miner: On the basis of and manner sta	examination a	nd/or inve	estigation, in my op	inion, death occurred	at the time, dat	e and place, and d	ue to the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier	(()			29c. License		290	d. Date signed (Mo	nth, Day, Year)
			1 fenti	10000	M.D)	D2	0274		October	12, 2004
	3		30. Name an address of person who	completed cause of d	eath (Item 23a)	(Type, P	rint)			10-2	
			Kirti Vohra,				*	esda, MD 2	20817		
	Sta	te	31. Date filed (Month, Day, Year)		ar's Signature	1.	/				
ě	Registr	ar	OCT 14 20	104 Sene	var /	9	Sparks				

DHMH 17 Rev 1/2001

ORIGINAL

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 04 34328

Certificate of Death

							Cen	iticate of	Death			Reg. No.			
	Physician /Medical	1. Decedent's Name	(First, Middle, L	ast) CATHEI	RINE	ELSI	E FI	RIESE			2. Dete of De Month OCT	Dey	Year 04	3. Time of Death 5:10 AM	1
	Examiner	4e Facility Neme (If I	not institution, g	ive street end nu	ımber)				4b. City, To	wn, or Lo	ocation of Deet	h 4c. Count	y of Death		
		WESTMIN									ISTER		ROLL		
ľ	Funeral Director	5. Social Security Nur 214-16-1	1789	Sex 1□M 2\S		yrs. lest birtl 83 Y		Months Deys		24 Hrs. Min.	8. Date of Bir (Month, Da 8 / 1 7 /	th ly, <i>Year)</i> 1921	9. Birthp Coun MARY	lace (State or Foreig try) LAND	n
	pue 🌲	Usuel Residence of D	Decedent 10b. County		100	. City, Town	or Loca	ntion					1.	0d. Inside City Limits	
	oth with the Maryler 23e or 28e-f show ust be notified at rai Director	MD	CARRO	LL		ESTM								1 ☐ Yes 2\(\frac{1}{2}\) No	
	or 2	10e. Street end Numi	ber					10f. Zip Code				10g. Citizen of	What Coun	try?	
	eth w	99½ LIBE	ERTY ST						1157			USA			
0	72 hours effer deeth with the Marylend naturel', or thems 23s or 28s-f show alsal Exeminer must be notified at ested by Funeral Director	11. Marital Status 1 ☐ Never Marrie		12. Was Dec Armed Fo 1 Yes If Yes, Gi	orces? 2X No	n U,S.		es Decedent of H Yes, specify Cub ☑ Yes 2☑ No			ecify Yes or No Rican, etc.)		ce - Americ ick, White, o by: WHI	etc.	
000	urel', o	3 ☑ Widowed 4		Year or D	Dates:				101						
5	nath rollica	(Specify	15. Decedent's I <i>y onfy highest g</i>	Education re <i>de completed)</i>		16e. I	Give kii	nt's Usuel Occup nd of work done O NOT use retire	etion during mos	t of work	in <i>g</i>	16b. Kind of B	Business/Inc	lustry	
21215-0020	ed within 72 hor ygiene. Ygiene. Yr, I'm Medical is t, I'm Medical is	Elementary/Second 1 2		College (1-4or 5+)			SCHOOL	WORK	ER		EDUCA			
Maryland	Mentel Hy Mentel Hy srked othwartic event	17. Father's Neme (F	First, Middle, Las	MERVIN	1	CLC	SE			er's Name		Maiden Surnai	me)		
	d 2 sho th end 7 is ma traum	19a. Informant's Nan GARLAND	•		SON			Address (Street							
Baltimore,	Peges 1 an ent of Heel nt: If Item 2 ry or other	20a. Method of Dispo 1 X Burial 2 4 Donation 5	Cremation 3			cemetery	. creme	tion (Name of tory or other place S CEME!	ce) FERY	10	Date / 1 4 / 0 4	20c. Location WESTI		ER, MD.	
Balti	permit. Pege Depertment of Important: If any Injury or once.	21. Signatus	rel 9 rvice Lice	ensee				Name end Addre							
		23a. Part / Enter the shock, or heart	disease, or co	mplications that	caused the d	leath. Do no	ot enter	the mode of dyir	ng, such es	cerdiac o	or respiratory a	rrest,		Approximate	
18	Physician /Medical	Immediate Cause (Fi	inal								. 1			Interval Between Onset end Death	
	Examiner 5	resulting in death)		1	Due to	o (or as a co	onseque	erlan	100		l.	0.000		2-4	
	executed or and risk-transit Examiner	Conventially list cons	ditions (b. 1		o (or es a co			Vas	en	in 2	eview.		15 p	
o,	en en en rich-tr	Sequentially list condification if eny, leading to immorate cause. Enter Underly Ceuse (Diseese or in	nediate ying		500 .	0 (0. 00 0 0	mooquo	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					1		
68760	ysici he bu	Ceuse (Diseese or in that initieted events resulting in death) La		c	Due to	o (or es e co	nseque	nce of):							-
39 xo	nding physicien and use as the buriel-transit n/Medical Examir			d											
m	d for	Part II. Other signification	ant conditions	contributing to d	eath but not	resulting in	the und	erlying cause ois	on in Part I		23h Did	obecco use co	ntribute to	the cause of death	2
P.O.	the death d by the ette leteched for Physicia	Turrii Guror organica	ant conditions	continuating to a	outil out not	resulting in	ino unigi	onying cause gre	on in parti	•		Yes 25 No	3 □ Prob		
	es that igned I be det by P											2.00110	0_1100	abiy 4 dinasa	
Vital Records,	been s should											an eutopsy rmed?	ava	re autopsy findings ilable prior to appletion of cause	
Re	e hes										arm	ras SZINo		eath? Yes 2⊡ No	
ta	ificet or, po	25. Was case referre	ed to medical						26 Place	of Dooth	(Check only o	٦		795 20 140	-
	Physician: rthis certific and director, r: To Be (examiner?		Hospital:	Inpatient 2	ER/Outr	atient	3□ DOA Oth	or:			dence 6 □Oth	er (Specify	1	
0	a Physical control of T. T	27. Menner of Deeth		28a. Date	of Injury	28b. Tir	me of	28c. Injur	y at			now injury occur		,	\neg
<u>o</u>	Attending or death. octor: After by the fune	1/ Naturel 2 Accident	5 Pending investigetion		th, Dey Year) inj	ury	M 1	κ? Yes 2⊡I	No					
Division	tal or Attending P rs efter death. el Director: After t led in by the funer: Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	200. Place	of Injury - A	at home, farr	n, streel	t, factory, office		- 1	28f. Location (5 City or Tox	Street and Numb m, State)	per or Rurei	Route Number,	
	To the Hospital or Attending Physician: The Is within 24 hours effer death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	29a. Certifier (Check only 2 one)	Certifying P Medical Exa	hysician: To the miner: On the band man	best of my lasis of exam	knowledge, inetion end/	death or	ccurred et the tir stigation, in my o	ne, date and pinion, deal	d place, e	end due to the o	cause(s) end ma date and place,	anner es sta end due to	ited. the cause(s)	
	within To the compl	29b. Signature and tit	tle of certifier	1-	0			29c. Licens	e number			29d. Date signe	d (Month) D	Pay, Yeer)	7
	La de	Robbr	n W	Druk	elleto			Da	4	43	3	10/	12/	2004	
	All	30. Name and addres	ss of person who	Completed caus	se of deeth (I	00 6	ype, Pri	1	a al	. 14	lesten	11h c7	4,	11) 211	7
	State Registrar	31. Dete filed (Month,	Day, Year)		tegistrer's Si	gnature	4	railes)		<i>+ + 1 - 1 /</i>			
			NOI TO		- Andrews	-	19								- 1

State of Maryland / Department of Health and Mental Hygiege 0 0 4 34329 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** HAROLD October | 2004 6:12 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LAUREL REGIONAL HOSPITAL LAUREL PRINCE GEORGE'S 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 1929 9. Birthplace (State or Foreign (Month, Day, Year) | 1939 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 19 **Funeral** 1 X M 2 F Yrs September 23 Director 75 North Carolina 246-34-3857 Usual Residence of Decedent with the Marylend 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show r than "natural", or iteme 23a or 28a-f shov the Medical Examiner must be notified at Prince George's Riverdale 1X Yes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20737 5408 62nd Avenue U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married 1 XYes 2 NoArmy Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black þ Specify: 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Mail Clerk Government 10th other 18. Mother's Name (First, Middle, Maiden Surname) permit. Peges 1 and 2 should be filk Department of Health and Mental Hy importent: if Item 27 is marked othany injury or other traumatic event 17. Father's Name (First, Middle, Last) Be Elizabeth Gudger Clarence Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eunice J. Gudger/Wife 5408 62nd Avenue Riverdale, Maryland 20737 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Maryland Vetern's 10-19-04 Cheltenham, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility $\,$ J. $\,$ B. $\,$ Jenkins Funeral Home once 7474 Landover Road Landover, Maryland 20785 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Malignant Neoplasm of Brain /Medical Due to (or as a consequence of): Examiner Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the attanding physicien end hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760. Physician/Medical d IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ pe Renal Failure 1 ☐ Yes 2 ☐ No 3 Probably 4 ₩Unknown 2 should been s Be Completed 24b. Were autopsy findings available prior to completion of cause of death? Cardiomyopathy 24a. Was an hes autopsy this certificate 1 ☐ Yes 2X No 1 Yes 250 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient examiner? Other: 1 Tes 2 X No Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation efter death Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral L Hospitel 1 X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MID D23181 gers 10-15-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 704 Gorman Avenue # 7-1 Laurel, Maryland 20707 R. G. Bhojraj M.D.

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

1 8 2004

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygie 26 114

			1 - State Registrar Amend #4a Pe			e <i>rtificate</i> d		id Mental Hyç	Reg. No.	34330
CR.	Physici /Medic		1. Decedent's Name (First, Middle, La	M	GA	2E601	24	2. Date of Dea Month	Day Year	3. Time of Death 0 9 55 4,M
	Examin	er	4a. Facility Name (If not institution, giv	e street and number	ashington	4b. City, Tow	n, or Location of D	Death	4c. County of Death	1
			to Art en Adv	entist Hos	pital)	TAKO		ARU MO	MONTO	onema
	Funeral Director		5. Social Security Number 6. S 412-01-9036	Sex 7. Ag IXM 2□ F	9 (In yrs. last birthda 91 Yrs.	y) If Under 1 Ye Months Da		Hrs. 8. Date of Birtl (Month, Day Mar. 31	h y, Year) 9. Birth Cou	place (State or Foreign- intry) rginia
	yland		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Ba-fsl	Director	DC				Washin	gton		1 X Yes 2 No
	ith th or 28	Dire	10e. Street and Number			10f. Zip Coo			10g. Citizen of What Cou	intry?
	s 23e			3rd St., S		N D (C-1	20020		United	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exam and must be notified at ances.	Completed by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 ff Yes, Give Year or Dates:		If Yes, specify (? (Specify Yes or No- luerto Rican, etc.)	14. Race - Amer Black, AVFite Specify: Ame	rean
215-0036	hin 72 ho s. in "natur Medicul	pleted	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		(Gi	cedent's Usual Oc ve kind of work do . DO NOT use re	ne during most of	working	16b. Kind of Business/li	ndustry
7	giene gerthe	Com	12th		,,,,	Dr	vcleaner		Self-Emp	loyed
n	be file tal Hy d oth event	Be	17. Father's Name (First, Middle, Last				18. Mother's	Name (First, Middle,	Maiden Sumame)	
<u>=</u>	d Men narke	7	William Gr			in the same			a Huntley	
Maryland	d2sh th and t7 is n traun		19a. Informant's Name/Relationship (George M. Grego	**	19b. Ma			., S.E. Wa	r, City or Town, State, Zi	p Code) 020
<u>ര</u> ്	s 1 an f Heal item 2 other		20a. Method of Disposition	27 2011	20b. Place of Dis	position (Name o		Date	20c. Location - City or T	
Ë	Page: ient o nt: If i		1 ☑ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Special			rematory`or other Memoria	1	0/15 / 2004	Suitland,	MD
Baltimore,	permit. Departm Importa any inju		21. Signature of Funeral Service Lice	nsee A	7	22. Name and Ad	dress of Facility	Stewart	Funeral Hom	e
	40240		23a. Part1 Enter the disease, or com	plications that caused	the death. Do not s			Rd., N.E.		20019 Approximate
	Physician /Medical		shock onheart failure. List only Immediate Cause (Final disease or codition resulting in death)	a. ASC	vD	THO THOUS OF	aying, such as car		1651,	Interval Between Onset and Death
	Examiner			non	a consequence of):	AILL	DE			
	ستست	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	U	a consequence of):	7/100				
	acuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
68/60,	rificate be executed to physician and as the burial-transit	Due to (or as a consequence of): d.								4 Th R. (II)
			IF FEMALE:							
C. BOX	res that the death cert igned by the attendin be detached for use	by Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 □Ectopic pregna 5 □ Other (s <i>pecif</i> y			23d. Date of defive Month	ery Day Year
S, D	The law requires that the ate has been signed by th page 2 should be detache		Part II. Other significant conditions	contributing to death b	ut not resulting in the	underlying cause	given in Part I.		obacco use contribute to	-1
Hecord	The law requir	Completed						24a. Was a autop:	sy prior to co med? death?	opsy findings available impletion of cause of
Vital	19 —	Be C	25. Was case referred to medical				26. Place of	1 ☐ Yes Death (Check only or	2 No 1 Yes	2LJ N0
<u>-</u>	Physician: r this certific ral director,	ToE	examiner? 1 Yes 2 No	Hospitaf: 1 ☐ fnpatie	nt 2 ER/Outpat	ent 3 DOA	Othor		lence 6 Other (Speci	fy)
ion of	ding h. After fune		27. Manner of Death 1		Year) 28b. Time	/	njury at Nork? Yes 2 No	28d. Describe h	ow infury occurred	
Division	o it	Certification:	3 🗍 Suicide 6 🗍 Could not be determined		ury - At home, farm, c. (Specify)	street, factory, offi	се	28f. Location (S City or Town	itreet and Number or Rur m, State)	al Route Number,
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	edicai (29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example 1	nysician: To the best miner: On the basis of and manner sta	examination and/or	ath occurred at th investigation, in n	e time, date and p ny opinion, death o	lace, and due to the coccurred at the time, c	cause(s) and manner as s date and place, and due t	stated. o the cause(s)
	To th Withir To th comp	M	29b. Signature and title of certifier	2		29c. Lic	ense number	2	29d. Date signed (Month.	Day, Year)
1	1			Mn		Mr	004	69319	10,06	2004
1	(3)		30. Name and address of person who DARCIE W	completed cause of d	eath (Item 23a) (Typ	, 000	Carroll AH E	Ave., Tal	koma Park, N	ID 20912
	Sta Registi		31. Date filed (Month, Day, Year) OCT 1 8 200		ar's Signature					

		1	_ FOr	artment of Health and Mer	ntal Hygiene
			Decedent's Name (First, Middle, Last)	2.	Date of Death 3. Time of Death
	Physicia		Charles Cataldo Guiliano	00	Month Day Year CTORER 21 2004 12:55 a
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1			St. Mary's Hospital	Leonardtown	St. Mary's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 1 ★ M 2 □ F 7. Trs.	Months Days Hours Min.	Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
	Director		195-20-2377 77 Yrs. Usual Residence of Decedent	A	ug. 24, 1927 Pennsylvania
	land		10a. State 10b. County 10c. City, Town or U	ocation	10d. Inside City Limits
	Mary	Ď	Maryland St. Mary's Mechan	icsville	1 □Yes 2 X No
	r 28a	rec	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	h with	a D	40396 Bay Drive	20659	U.S.A.
	deat	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13 Armed Forces?	Was Decedent of Hispanic Origin? (Specifit Yes, specify Cuban, Mexican, Puerto Ric	y Yes or No- 14. Race - American Indian, an, etc.) Black, White, etc.
98	or its	F	1 Never Married Married 1X Yes 2 No	1 ☐ Yes 2X No Specify:	Specify:
00	ural',	d by	3 Widowed 4 Divorced Year or Dates: WW II	death librat Occuration	White
15	n 72	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
12	withii ene. then	шс	Elementary/Secondary (0-12) College (1-4or 5+)	rpenter	U.S. Government
9	Hyg Hyg othar	BeC	17. Father's Name (First, Middle, Last)		irst, Middle, Maiden Sumame)
<u>la</u> n	uld be fental rkad rkad	To B	Cataldo Guiliano	Nina Cie	1i
Baltimore, Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other then "naturel", or items 23s or 28s-f show or other traumatic event, the Medical Examinating must be notified at		19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ing Address (Street and Number or Rural R	loute Number, City or Town, State, Zip Code)
Σ	and 2			6 Bay Drive Mechanic	sville, MD 20659
ore	of He of He fitam	1	20a. Method of Disposition 20b. Place of Disposition 20b. Place of Disposition 20cemetery, cr	position (Name of Date ematory or other place)	20c. Location - City or Town, State
Ĕ	Pa ant ant		'4 □Donation 5 □Other (Specify) MD Vets	. Cemetery 10-27	-04 Cheltenham, Maryland
alt	permit. Departm Importa any inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Brin	sfield Funeral Home, P.A.
Ш	205 g g		1 My K1320 111011124		dtown, Maryland 20650
			23a. Part 1. Enter the of ease, or comblications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	The state of the s	espiratory arrest, Approximate Interval Between Onset and Death
	Pnysician		disease or condition	my dalure,	
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	0	
		_	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of):	non1a	
	pel	Examiner	cause. Enter Underlying Cause (Disease or injury		d d
_6	sician and burial-transit	xar	that initiated events resulting in death) Last C. Due to (or as a consequence of):		
8760,	ate be executed hysician and the burial-transli	dicai E	d		
89		edic			
Box	eath certific attending p for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy	23d. Date of delivery
B.	ne deat the atte	sicia	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)	Month Day Year
P.O.	that the death cer ed by the attendin detached for use	hys	9 LJ Unknown		
s,	w requires that s been signed t s should be det	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown
ord	equir	ted			
Division of Vital Records,	elawr hasbe ye 2 sh	Completed			24a. Was an autopsy autopsy findings available prior to completion of cause of
=	The page	Son			performed? death? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No
/ita	ician: Th certificate rector, pag	9	25. Was case referred to medical examiner? Hospital:	26. Place of Death (C	Check only one)
of	Physi this c	2	1 195 2 140 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ant 3 DOA 4 Nursing Home	5 Residence 6 Other (Specify) 1. Describe how injury occurred
on C	ting I	ioi	1 Natural 5 ☐ Pending (Month, Day Year) Injury		2. Describe flow injury occurred
isi	death ctor: / the	Certification;	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm.		Location (Street and Number or Rural Route Number,
<u>></u>	lor A after Dira	ertii	4 Homicide determined building, etc. (Specily)		City or Town, State)
_	To the Hospital or Attanding Physician: The law requires that the death certific within 24 hours after death. To the Funaral Diractor: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 Certifying Physicien: To the best of my knowledge, de	ath occurred at the time, date and place, and	d due to the cause(s) and manner as stated.
	P Ho	edical	(Check only one) 2 Medical Exeminer: On the basis of examination and/or and manner stated.	nvestigation, in my opinion, death occurred	at the time, date and place, and due to the cause(s)
	To th Withir To th comp	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	20		> -DShah	D 47066	10.22-04
4	50		30. Name and address of person who completed cause of death (Item 23a) (Type	e, Print)	
			AVANI D SHAH PO BX404 LEONARDTOW	N MD 20650	
		ate	31. Date filed (Month, Day, Year) OCT 2 5 2004 32 Registrar's Signature	Coull 1	
	Regist	rar	ULI WU ZUU4 DEMAN SO SO	A STATE OF THE STA	

DHMH 17 Rev 1/2001

CHARLES GUILIANO

State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death 004 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** James Harley Gillispie 2004 October 658 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Cookesville Howard I-70 at Route 97 8. Date of Birth (Month, Day, May II, 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Hours Vrs 212-28-2637 Director 75 Vírginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10a State 10c. City. Town or Location 10d. Inside City Limits 10h County r Items 23a or 28a-f shor ther must be nutified at 1 ☐ Yes 2 XNo Director MD Baltimore Parkton 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 21120 U.S.A. 18107 York Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: other traumatic svant, if a Madical Exer-3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Cable Technician Communication 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be Kirby R. Gillispie Ollie E. Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernice A. Gillispie/Wife 18107 York Rd., Parkton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Oct. Date 26, 20c. Location - City or Town, State ₽ = 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 0 permit, Page Department of Important: If any injury or once. Wiseburg Cemetery White Hall, MD * 4 ☐ Donation 5 ☐ Qther (Specify) 21. Sanature of uneral Service 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc 24 Second St., New Freedom,PA . Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Multiple Immediate Cause (Final Physician In WIES disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. physician Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. the à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, þ 1 Yes 2 XNo 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? director, page 2 2 No 1 Tyes or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other 4 Nursing Home 5 Residence 6 Other (Specify) at scene Hospital: 1 XYes 2 ☐ No P 1 Inpatient 2 ER/Outpatient 3 DOA of 28c. Injury at Work? 27. Manner of Death Date of Injury (onth Day Year) 28b. Time of Certification: 28d. Describe how injury occurred . After Division 1 Natural 5 Pending investigation Injury death. 6:42AM 1 ☐ Yes 2 No after death. 10 22 04 2 Accident PASSEJEVET Auto involved in collision 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 170 a + RUNE 97 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide Hampied county. STYEDT MD 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To tha 29d. Date signed (Month, Day, Year) October 22, 2004 29c. License number OCME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar JACKEM, 32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene OLA 34333 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 18, 2004 **Physician** Delcie Helen Gullion 12:30 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** North East Cecil 101 Louise Court If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. March Day, Year 945 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F 59 West Virginia 232-72-5172 Yrs. **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director MD Cecil North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 101 Louise Court 21901 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No þ Specify: White 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In home permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Helen Virginia Blankenship Roy A. Snedegar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul F. Gullion (Spouse) 101 Louise Court, North East, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Slate 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Mem. Gdns. 10/21/04 Bel Air, MD *4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LIVER LANCER Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 2 No Month 4 Pregnant at time of death 5 Other (specify) the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 □Unknown Completed peen 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ₺ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t Certification: Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funerel Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) July Halstead mo D0020803 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1200 BRASS mill RD BELLAMA 31. Date filed (Month, Day, Year) 32. Regulrar's Signature OCT 2 0 2004 Registrar

and Mental Hygiene

	For	State of Maryland	Department of Health
-	State Registrar		Certificate of Deat

Reg	. No.				
Death	20	\overline{n}	L	2 3.	Time of

2. Date of

36 s after death with the or Items 23e or 28	21215-0036 led within 72 hours after death with the lygiene. lygiene returel', or ltems 29e or 28 her then "neturel', or ltems 29e or 28 it, the Medical Exam net must be not	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturer", or Items 23e or 28e-f show any injury or other treumetic event, the Medical Examinar must be invilided at		Direct show
	21215-000 Ed within 72 hours lygiene. Per then "neturel", the Medical Ex.	, Maryland 21215-00; and 2 should be filed within 72 hours alth and Mentai Hygiene, 127 is marked other then "neturer, er freumetic event, the Medical Ex-	99	safter death with the

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1. Decedent's Name (First, Middle, Last)

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Physician /Medical **Examiner**

Division of Vital Records, P.O. Box 68760,

Month OCTOBER 17, 2004 **Physician** Charles Francis Gaughan 07:00 a. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS Memorial Campus Hospital ALLEGANY CUMBERLAND If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 11/19/1934 Birthplace (State or Foreign Country)
 PA 5. Social Security Number 6. Sex Days Hours 220-32-2709 1**X** M 2□ F 69 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Oldtown Allegany 1 ☐ Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18703 Oldtown Road, 21555 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify.White 1 ☐ Yes 2 ☒ No Specify: 3 ☐ Widowed 4 ☐ Divorced WWTT 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Textile 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Joseph Gaughan Helen Mae (Baker) Gaughan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dottie Lou (Wolfe) Gaughan/Wife 8703 Oldtown Road, SE, Oldtown, MD 21555 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State Cumberland Crematory 10/18/2004 Cumberland, MD ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, FA 21. Signature of Funeral Service Licensee 404 Decatur Street, Cumberland, MD 21502 adams 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition CARDIAC ARREST 30 MIN. resulting in death) Due to (or as a consequence of): ACUTE MYOCARDIAL INFARCTION 30 MIN. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 12 No 3 Probably 4 Unknown certificate has been Were autopsy findings available prior to completion of cause of death?
 □ Yes 2 □ No autopsy performed 2 No 1 Yes funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 Yes 2 No death. 2 Accident investigation after death Director: / filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3/IVA OCTOBER 18 2004 D14865 Reteartano James 9. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barrera M.D. 500 Memorial Avenue Cumberland, Maryland 21502 Robustiano J. 31. Date filed (Wenth, Day, Year) 82. Registrar's Signature State

Registrar DHMH 17 Rev 1/2001

			For State	State of	f Maryland		artment <i>rtificate</i>				ntal Hy	giene	nnl.	21.2	35
			Registrar 1. Decedent's Name (First, Midd	fle, Last)			rimoato	01 0	Calif	2	. Date of D	Reg. No.	104	3. Time of	Death
	Physic		MICHELLE 1	DENISE HIC	CKS					Od	Month	nth Day Yeer		8:45	Ам
	/Medi Examir		4a. Facility Name (If not institution				4b. City, T	own, or Lo	ocation o				ounty of Death		
			7118 Columbia	Park Road		•	Hvat	tsvi	11e			Prin	ce Geo	rge's	
	Funeral		5. Social Security Number		7. Age (In yrs. las	,,	If Under 1	Year I	If Under :	24 Hrs. 8 Min.	. Date of Bi (Month, D	rth		place (State o	or Foreign
	Director		072-46-3865	1 M 2 X	50	Yrs.					arch	23,195	4 Glen	cover,	NY
	land		Usual Residence of Decedent 10a. State 10b. County	у	10c. City, 1	Town or Lo	ocation							10d. Inside Ci	ity Limits
	Mary -f sh	ţō	Maryland Prince	George's	Hyat	tsvi	11e							1 📉 Yes	2 🗆 No
	h the	Director	10e. Street and Number				10f. Zip (ode				10g. Citizer	n of What Cou	ntry?	
	th wit		7118 Columbia	Park Road				207	785				USA		
	r dea	Funeral	11. Marital Status	12. Was Dece Armed For		13.	Was Decede	nt of Hisp y Cuban,	anic Orig	gin? (Specif	y Yes or No	0- 14.	Race - Ameri Black, White,		
36	be filed within 72 hours after death with the Maryland hat Hygiene. Independent in aturel, or frams 23a or 28e-f show event, the Medical Exacting trinst be notified at	byF	1 ☐ Never Married 2 ☐ Mai 3 ☐ Widowed 4 ☐ Divorce	II Tes, GIVE	θ	1	1 Yes 2	_	Specify:				pecify:		
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215	Z un Z	Completed	(Specify only higher Elementary/Secondary (0-12)	est grade completed)		(Give	kind of work DO NOT use	done duri	ring most	of working		TOD. AIRG	01 003111033/11	idustry	
212	d with giene. er ther	E	12th	College (1-		Admin	nistra	tive	Ass	istan	t	PG Go	vernme	nt	
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yla	2 should b and Menta Is marked raumatic e	2	Colin Willi							dred 1					
Maryland	2 8 9 1		19a. Informant's Name/Relation										own, State, Zip		
	s 1 and 2 of Health item 27 l		Michael Hicks/ 20a. Method of Disposition	nusband			sition (Name		ark I	ROAG Date	-		e, Md.		
٥	~ ~ .		1 ☐ Burial 2 ☐ Cremation		State cem	etery, crer	natory or oth	er place)							1
Baltimore,	교본분들		* 4 □ Donation 5 □ Other (\$\frac{3}{21}\$. Signature of Funeral Service		MILL	22	L Bapt 2. Name and	Address of	of Facility	v			ro, No	rtn Ca.	LOTIU
ä	Depar Impor any ir		Show of	With me	21320	F	razier	's Fu	uner	al Ho	-		0001		
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that ca	used the death. I	Do not ent	39 R.I er the mode	of dying, s	such as o	cardiac or re	wasn espiratory a	DC 2	0001	Approximate Interval Bety	9
	Physician		Immediate Cause (Final disease or condition		Cancer	_ He	natoce	11-1:	ar					Onset and D	
1	/Medical Examiner		resulting in death)		or as a consequen		Paroce	TTGIC	a.						
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	ed ssit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (d	or as a consequen	ice of):									
	xecul	Examine	that initiated events resulting in death) Last	c Due to (c	or as a consequen	ice of):									
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9		0										1			
Вох	death certifii e attending p id for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant		ome of pregnancy		Ectopic preg	nancy				23d	Date of delive	•	
	0 0	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		int at time of death		Other (spec						Month	Day Y	ear
P.0	that the		Part II. Other significant conditi	ons contribution to des	ath hut not reculting	a in the u	adoshina osi	co awaa i	in Port I		22a Did t	abassa usa	contribute to the	a souss of de	anth?
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Σ	Physicien: this certific ral director,	To B	examiner?	Hospital: 1 □ In	patient 2 ER	/Outpatien	t 3 DOA	Other			**		Other (Specifi	v)	
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Division		ertification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 286. Place C	of Injury - At home g, etc. (Specify)	, farm, stre	eet, factory, o	office		28f.	Location (S City or Tox		umber or Rura	l Route Numb	oer,
	Hospitel	O	29a. Certifier 1 Certifyin	na Physician: To the h	and of my knowle	doo dooth		the time o	dete d						
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	edicai	(Check only 2 Medical one)	ng Physician: To the b Examiner: On the bas and manne	sis of examination	and/or inv	estigation, in	my opinio	on, death	n occurred a	at the time,	date and pla	manner as st ce, and due to	ated. the cause(s)	
	To the within 2. To the complet	Me	29b. Signature and title of certifie	or Malla	. 114		29c. I	icense nu	umber			29d. Date si	gned (Month, I	Day, Year)	
			1 (mother	III Clau	4 Mit		ם	39532	2			Octobo	r 13,	2004	
D	(7)		30. Name and address of person	who completed cause	of death (Item 23	a) (Type, i	Print)			2		CLODE			
1	9		Timothy Mc				rince	Georg	ge S	treet	Lau	rel, M	arylan	d 2070	4
	Sta Registr		31. Date filed (Month, Day, Year) OCT 18		gistrar's Signature										
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State of Maryland / Department of Health and Mental Hygin 1	٠

			1 - For State of Maryland / Department of Health and M Certificate of Death	ental Hygien	
	Physic /Medi	cal	1. Decedent's Name (First, Middle, Last) BESSIE JEANNETTE HOFFMAN	2. Date of Death Month Da	18,2004 7:14A M
	Exami	ner	4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center Towso		c. County of Death Baltimore
	Funeral Director		5. Social Security Number 218-34-3953 6. Sex 1 Months 1 M	8. Date of Birth (Month, Day, Year MARCH 1, 1	9. Birthplace (State or Foreign Country) MARYLAND
	Maryland a-f show	tor	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 ☐ Yes 2 ☑No
	with the e or 28¢	Director	10e. Street and Number 10f. Zip Code	10g. C	itizen of What Country?
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "naturel", or items 23e or 28e-f show or other treumetic event, the Medical Examinational be invitibled at	by Funeral	If Yes, Give 1 ☐ Yes 2 ☑ No Specify: Year or Dates:	cify Yes or No- Rican, etc.)	U.S.A. 14. Race - American Indian, Black, White, etc. Specify: WHITE
Maryland 21215-0036	within 72 ho iene. 'then "natur ite Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER	ng 16b. h	(ind of Business/Industry OWN HOME
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aryla	2 should be and Mental Is marked commetic ev	2	HARRY EDGAR KEPHART 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural	IRGINIA SHO	
	1 and 2 Health a lem 27 Is		DEBRA A. RIDENOUR, DAUGHTER 21604 RIDENOUR ROAD, I	BOONSBORO,	MARYLAND 21713
Baltimore,	Pages nent of P int: If it		1∑ Burial 2 □ Cremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify) 1 □ LENA CEMETERY 10/21/	100.0	ocation - City or Town, State OONSBORO, MARYLAND
Balti	permit. Pages Department of Importent: If i eny injury or once.		21. Six surre of Briefal pervice icensee 22. Name and Address of Facility BAST FUNERAL HOME	7606 OLD	NATIONAL PIKE O, MARYLAND 21713
	Physician		23a. Part 1. Atal Me disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. MYOCARDIAL INFARCTION	r respiratory arrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence of):		
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8760,	icate be executed physician and s the burial-transit	/Medical Exa	that initiated events resulting in death) Last C Due to (or as a consequence of): d		
.O. Box 6	death certif e attending id for use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of delivery Month Day Year
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cord	w requir been si should	leted	END STAGE RENAL DISEASE	1 ☐ Yes 2	□ No 3 □ Probably 4 ☑Unknown 24b. Were autopsy findings available
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of	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	atlon; To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Hom	e 5 Residence 8d. Describe how injure	
Division	tel or Atters after des el Directo	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	Bf. Location (Street an City or Town, State	d Number or Rural Route Number, s)
	To the Hospitel or within 24 hours afte To the Funerel Diracompletely filled in It	edical	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	nd due to the cause(s) d at the time, date and	and manner as stated. I place, and due to the cause(s)
	To the within 2. To the complet	Me	29b. Signature and title of cartifler 29c. License number	29d. Dai	te signed (Month, Day, Year)
,	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	10	119104
	of the		ANALYSIS TO THE CONTROL OF THE STATE OF THE		34
	Sta Registr		31. Date filed (Month, Day Year) OCT 2 0 2004 32. Redistrar's Signature Specific		

			For State Registrar	State of Marylar	id / Depa	artment of F tificate of	lealth and M Death	Mental Hyg	ene 004	34337
Ī	Physici		1. Decedent's Name (First, Middle, Last) Harry Donnel	1 Holmes				2. Date of Death Month Octob		3. Time of Death 4:45A M
2	/Medic Examin		4e. Fecility Name (If not institution, give s	treet and number)		4b. City, Town, o	Location of Death		4c. County of Dea	
	Funeral Director		1517 1st Stree 5. Social Security Number 6. Sex		last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth Month, Day, 9/6/19	9. Bird	chplace (State or Foreign ountry)
	D		Usuel Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Lo					10d. Inside City Limits 1) Yes 2 \(\) No
	with the M 3a or 28a-f	Funeral Director	MD P.G. 10e. Street and Number 1517 1st St.		Glen /	10f. Zip Code 20706		10	Og. Citizen of What Co	
036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or Items 23a or 28a-f ahow event, the Madical Examiner must be netified at	þ		12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: B	
21215-0036		Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired urier	during most of worl	king	Rind of Business	•
Maryland 2	should be filed vand Mental Hygie s marked other t umatic event, III	To Be C	17. Father's Name (First, Middle, Last) William C. Holn	nes				e (First, Middle, M		
	12 d 12	0.0	19a. Informant's Name/Relationship (Typ. Iris L. Holmes	oe, Print)					City or Town, State, 2 n, Md. 207	
Baltimore,	Pages 1 and nent of Healt int: If item 2 iry or other		20a. Method of Disposition PC Burial 2 Cremation 3 R. 4 Dogation 5 Other (Specify)	amoval from State	semetery, crer surre	sition (Name of natory or other plac ction C	em 10/	9/04 C	Oc. Location · City or linton , M	đ.
Balt	permit. Pages Department of the temperant: If ite any injury or of once.		21. Signatur of Funeral Service License	Levards) 22	Name and Address	ss of Facility Ho ver Hil	đges an 1 RD.Su	d Edward itland,M	d.20746
	Physician physician and physician and physician and physician and physician sit is physician than the physician phys	i Examiner	23a. Pay1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e cause on each line. Left Renal Due to (or as a consec	Ce11 juence of):		g, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death 2 months
.O. Box 68760,	death certifi e attending id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn; 1 □ Live birth 2 □ Fete 4 □ Pregnant at time of c	Ideath 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
ecords, P	as tha	by	Part II. Other significant conditions con	tributing to death but not res	sulting in the u	nderlying cause giv	en in Part I.		acco use contribute to s 2 □ No 3 □ Pr	the cause of death?
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Vital	Physicien: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	t 3 DOA Oth	er	th (Check only one	nce 6 Other (Spe	cifu)
lon of	ding After fune	ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor		28d. Describe ho		
Division	in Site	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, str fy)	eet, factory, office		28f. Location (Str. City or Town	eet and Number or Ru State)	ıral Route Number,
	To the Hospitel or within 24 hours after To the Funeral Direction completely filled in I	edicai	29a. Certifier (Check only one) 1 X Certifying Physical Control (Check only one)	ng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as : Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due land manner stated.						
ŀ	To the within 2 To the complet	Me	29b. Signature and title of certifier	ma	mig	USO Licens	MD15185		d. Date signed (Monte $0/14/04$	h. Day, Year)
7	2(8)			mpleted cause of death (Iter			TI- 1 -			
	Sta		John McKnight 31. Date filed (Month, Day, Year) OCT 18 2004	MD 110 Irv: Registrar's Signa	ature	N.W.	wash. I).C.		

State of Maryland / Department of Health and Mental Hygie () 1 - For Stata Ragistra Certificate of Death Reg. No. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician MARY IRENE HOFFACKER Month Day OCTOBER 14 2004 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 20751 WARFIELD COURT GAITHERSBURG MONTGOMERY 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country)
 PA Months Days Hours 1□M 25 F Year)902 215-46-3761 102 Yrs Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 28a-f show 10d. Inside Lity Limits must be notified at MD MONTGOMERY POOLESVILLE 1 Ves 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19501 LUHN STREET 20837 ftems 23a USA Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cyban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, other traumatic evant, the Medical Execution Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 ō 1 ☐ Yes 2 ☑ No Specify: WHITE 3 Widowed 4 □ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry nt of Health and Mental Hygiene.
: If itam 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE DOMESTIC 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be DANIEL SNYDER LAURA GARRETT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TREVA SOUDERS / DAUGHTER 19501 LUHN ST., POOLESVILLE, MD Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page:
Department o
Important: If
any injury or
once. MONOCACY CEMETERY 10/18/04 BEALLSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fu era Service Licens 22. Name and Address of Facility HILTON FUNERAL HOME P.O. BOX 86, BARNESVILLE, MD 20838 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) PNEUMONA Onset and Death Pnysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Usarana) Examiner Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 menths? 1 Tes 2 No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown Completed 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe 1 🗌 Yes 21 or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 ther (Specify) Group Home 1 ☐ Yes 21☐ No P this in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28c. Injury at Work? 28d. Describe how injury occurred Certification; 28b. Time of Diractor: After 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) zu Cuns D000995-MD 13 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 17600 W. WILLARD HEGTOR ATGUNCION , M.D. P00199 VIIIE 31. Date filed (Month, Day, Year) 32. Registrat's Signature State 18 2004 Registrar oaks

Amended #10e, nls, 10/18/04, Allegany Co.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie 10 0 1.

21, 239

			For State Registrar 1. Decedent's Name (First, Middle, Last)	State of Mary	Cer	tificate of l	Death	Reg 2. Date of Death	_	3. Time of Death
	Physicia	an	MARY MARGARET	r HAINES	}		0	Month CTOBER 1	Day Year 4. 2004	2130 ^M
3	/Medic		4a. Facility Name (If not institution, give st			4b. City, Town, or	Location of Death	CIODER I	4c. County of Deat	
6	Examin	er	MEMORIAL HOSPITAL			CUMBERLA			ALLEGANY	
	Funeral Director		218-16-2994	14 of 157 c	yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, YOCT • 21,	9. Birt 1926 MA	nplece (State or Foreign untry) RYLAND
	and w		Usuel Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits
	d eho	ō	MD ALLEGA	ANY	CUMBER	LAND				XIXYes 2 □ No
	128a	Director	10e. Street and Number 10f. Zip Code						. Citizen of What Co	untry?
	h with		721 DALE-STRI	EET- AVE		2150	_		U.S.A.	
21215-0036	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. d other then "naturel", or items 23e or 28e-f ehow event, I're Medical Examinal must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	 Was Decedent Ever Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 			ispanic Origin? (Specin, Mexican, Puerto F Specify:	cify Yes or No- lican, etc.)	14. Race - Ame Black, White Specify: W	
Ö	72 hou	ted	15. Decedent's Educ (Specify only highest grade	ation	(Give	dent's Usual Occup	during most of workin	g 16	b. Kind of Business/	Industry
21	thin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	USEKEEP	1)		HACDIM	7. T
21	filled wi Hygien other th		10 17. Father's Name (First, Middle, Last)		пО	USEREEP	18. Mother's Name	(First, Middle, Ma	HOSPIT	AL
Maryland	ntal H ed of	Be	BERT LEASE				ALICE	CHILCO		
Ž	s 1 and 2 should be I Health and Menta Item 27 le marked other traumatic ev	유	19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailir	ng Address (Street	and Number or Rural		The second second	Tip Code)
Ma	od 2 s lith an 27 le r trau		ROBERT HAINES		721	DALE AV	ENUE, CU	MBERLAN	ND, MD 2	1502
Baltimore, I	Page: ent o ht: If ry or		20a. Method of Disposition X∑Burial 2 □ Cremation 3 □ Re ' 4 □ Donation 5 □ Other (Specify)	amount from State	20b. Place of Dispo cemetery, crer	sition (Name of matory or other place	De	ate 20	c. Location - City or	
Balti	permil. Pa Departmen Important: eny injury once.		21. Signature of Funeral Service Lone	teschur	E.	202 GREEN	STREET.	CLIMBERL	AND, MD	21502
	Physician /Medical		23a. Part1. Enter the disease, or complications, or heart failure. List only on the sease or condition resulting in death)	e cause on each line.	Artery		ig, such as cardiac or	respiratory arres	t,	Approximate Interval Between Onset and Death 5 Years
68760,	ificate be executed g physician and ss the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to introducto cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co						
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S, D	juires that signed by	þ	Part II. Other significant conditions con Diabetes Mellit		eot resulting in the u	inderlying cause giv	en in Part I.		cco use contribute to	the cause of death? obably 4 Munknown
of Vital Record	The law requires ate has been si page 2 should I	Completed						24a. Was an autopsy performe	prior to death?	itopsy findings available completion of cause of
ital	sician: Th certificate rector. pag	Bec	25. Was case referred to medical examiner?				26. Place of Death	(Check only one)		
× ×	Physician: this certific ral director.	은	1 ☐ Yes 2 🌉 No	ospital:	2 ER/Outpaties		4 Nursing Horr		ce 6 Other (Spe	cify)
Division o	ttending P death. ctor: After t y the funera	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Yo		M 1	k? Yes 2 □ No	8d. Describe how		-12 - 1
DIV	Oire in b	Certifi	4 Homicide determined	28e. Place of Injury building, etc. (Specify)	1077		City or Town,		
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier 1 Gertifying Physical Check only 2 Medical Examinates	sician: To the best of n ner: On the basis of ex and manner stated	amination and/or in	th occurred at the till evestigation, in my o	me, date and place, a prinion, death occurre	nd due to the cau id at the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)
	To the I within 2 To the I complet	Med	29b. Signature and title of certifier	and manner stated	J	29c. Licens	a number	290	f. Date signed (Mont	h, Day, Year)
	₹ ¥ 5 8		Y L. D.	m		D332	280		OCTOBER	رِيرَ , 2004
	nes		30. Name and address of penun who co		th (Item 23a) (Type.)1 CUMBER	LAND, MD	21502	
9	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's		Sparks				
1	Regist		001 1 0 2004		1 1	poras				

		For State Registrar	State of Maryla	nd / Depa		lealth and I	Mental Hygi		34340		
Physicia /Medica	n ai	Decedent's Name (First, Middle, Last) Dorothy Dick Hol As. Facility Name (If not institution, give see			4b City Town or	Location of Death		Day Year	3. Time of Death 11:00 A M		
Examine		Potomac Valley No. 5. Social Security Number 6. Sex	ursing Home	. last birthday) Yrs.	Rockvil If Under 1 Year Months Days		8. Date of Birth	Montgome	ery thplace (State or Foreign ountry)		
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th with the M 23a or 28a-f	Funeral Director	VA Arlington 10e. Street and Number 2000 N. Glebe Road		clingto	10f. Zip Code 22207	7	10	g. Citizen of What Co	ountry?		
I Z I 3-UU30 within 72 hours after death with the Maryland ene. than "natural", or ftems 23e or 28e-f ahow he Madical Extraiter rates the ricitified at	by Funer	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	I2. Was Decedent Ever in the Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2🎇 No		pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whi Specify: Wh	te, etc.		
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nd A be filed tal Hygi d other	To Be Co	17. Father's Name (First, Middle, Last) Carl F. Dick				Lilian	e (First, Middle, Maiden Sumame) Taylor al Route Number, City or Town, State, Zip Code)				
fe, Mai		19a. Informant's Name/Relationship (Ty, Dick Hollands, So 20a. Method of Disposition	on 20b.	1027	•	anch Ct.	McLean,	City or Town, State, . Virginia Oc. Location - City or	22101		
Deficiency of the pages 1 a Department of Hee Important: If flem any injury or other pages.		1 ☐ Burial 2 ☑ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal (in) of Funer Service Liu nse	Ft	Linc	oln Crema 2. Name and Addres	tory 10/ ss of Facility	Simple Tr		•		
Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or tmmediate Cause (Finat disease or condition	cations that caused the classed cause on each line. Pneumonia						1 and 20852 Approximate Interval Between Onset and Death 1 week		
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Physician: The law requires tribis cardificate has been signer rail director, page 2 should be or	Completed						24a. Was an autopsy perform	ed? prior to death? No 1 □ Yes	utopsy findings available completion of cause of 2 No		
Afte fune	ition; To Be	25. Was case referred to medical examiner? 1 Yes 2 No H 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	28c. Injury Work	^{9r:} 4ሺ Nursing H ⁄ at	th (Check only one ome 5 Resider 28d. Describe hov	nce 6 ☐Other (Spe	cify)		
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, str ify)	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ro State)	ural Route Number,		
To the Hospital or within 24 hours afte to the Funeral Dir. completely filled in I	Medical		sicien: To the best of my kn ner: On the basis of examin and manner stated.			oinion, death occu	rred at the time, dat		to the cause(s)		
T O S O S O S O S O S O S O S O S O S O	Me	30. Name and address of person who co	mpleted cause of death (tte	m 23a) (Type,	erup D38			ctober 12			
Stat Registra	е	Dr. Mendhiratta, 24 31. Date filed (Month, Day, Year) OCT 14 2004	101 Research 32 Registrar's Sign	Blvd.			le, Maryl	and 20850			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month GEORGE HIMES 7,2004 October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 6. Sex 8. Oate of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 XM 2□ F Hours Director 218-03-7964 9/5/1917 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Itams 23a or 28a-f shot traumatic evant, Ite Madical Examiner must be notified at Director MD. FREDERICK **JEFFERSON** 1 Tyes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4550 CAP STINE RD. 21755 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: WW I I Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No ð Specify: WHITE 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) STOCKER GROCERY STORE 9 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill timent of Health and Mental H tant: If itam 27 Is marked out 18. Mother's Name (First, Middle, Maiden Sumame) Be ALBERT HIMES LUCY CORUM ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a itam 27 ls rother tra STEPHEN HIMES - SON 4550 CAP STINE RD., JEFFERSON, MD. 21755 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) = 5 permit. Page Department of Important: If any injury or once. COUNTY CREMATION 10/8/04 SYKESVILLE, MD. ⁴ 4 □ Donation 21. I gnature of 194 M Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Of to (or as a consequence Physician 0410 disease or condition resulting in death) /Medical to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy ţō in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) ed by the a of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 3 Probably 4 □Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autoosy performed' 1 🗌 Yes 2[To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: : After 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: / 6 Could not be determined 3 🗋 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completely filled in within 24 hours a To tha Funaral C 1 Pertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 29b. Signature and title of o 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT L. MD 300 WEST 9th ST., FREDERICK, MD. 21701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 3 2004 Registrar

State of Maryland / Department of Health and Mental Hygien 004 34342 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician JOHNSON** October 15 GLADYS 2004 10:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner PRINCE GEORGE'S HOSPITAL Prince George's Cheverly 8. Date of Birth (Month, Day, Tune 5 Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplece (State or Foreign Country) **Funeral** Months 213-46-5955 1 ☐ M 2 🛣 F Director 1944 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show the Madical Examiner must be notified at Capital Heights 1⊠Yes 2□No Director MD Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 9409 Firtree Park Street 20743 U.S.A. by Funeral or Itams 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced Black "naturel". Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Custodian Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First Middle Maiden Sumame) Be Pages 1 and 2 should be innent of Health and Mental ant: If item 27 is marked o JAMES. HAMILTON MAUDE BOONE WASHINGTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20743 permit. Pages 1 and 2 s Department of Health ar Important: if item 27 Is eny injury or other trau once. SHERMAN E. JOHNSON/HUSBAND 9404 Firtree Park Street Capital Heights, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Harmony Cemetery 10-20-04 Landover, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Le Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause, justice in justification of the cause of the Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit signed by the attending physician and dedecached for use as the burial-trar Division of Vital Records, P.O. Box 68760. by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been si 3/Q No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death ate of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day Year) 030318 30. vame and address of person who completed cause of death (Item 23a) (Type, Print) James Catevenis M.D. 3001 Hospital Drive Cheverly, Maryland 20785 31. Date filed (Month, Day, Year) 2. Registrar's Signature State 1 8 2004 Registrar

State Registrar

10-23-04

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	/Medic	al		ck Johnson		41 65 T	1		1 4 200 4		1:58A M		
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	Funeral Director		5. Social Security Number 6. Sex 201-24-6730 Usual Residence of Decedent	7. Age (In yrs	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec. 9,	Yeari	Country	ce (State or Foreign /lvania		
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920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural, or items 23e or 28e-f show any injury or other treumatic event. The Modical Examinar must be notified at once.	Completed by Funeral	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? X Yes 2 No If Yes, Give Year or Dates: 1951	!	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 🌂 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	Pecify Yes or No- Pican, etc.)	14. Race - A Black, N Specify:	American White, etc Whit			
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			1- State Amend Item 5 per fh 6836 I	d 29en Cer	artment of He 4 tas tificate of D	ealth and M Death		2004	34345
	Physici /Medic		Decedent's Name (First, Middle, Last) WILLIAM STEP	HEN K	LOSINSKI		2. Date of Death Month OCT 6	Day Yea	3. Time of Death 5:45 P M
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Ē	it. Pages intment of l intant: If it njury or o		 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 		Chu	rch Ce	metery Name and ddres		ct. 21, 2004		lfesville	
Ba	permit. Departn Imports eny inju		Jeffrey	Davis	M				ral Home S	2323 mith	Bradbury sburg,Md.	7 Ave. . 21783
	Physician	C I	23a. Fart 1 Emer the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition	cations that cause e cause on each I	d the death line.							Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to for as		rence of):	a m	TEA	1 10	450		
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as			1 1110	1192	PIJV	736		2 52 3
_	icate be executed physicien and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequ	ence of):						
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9	entifical ling phy e as th	Medi	IF FEMALE:									
P.O. Box	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as:	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetel	death 3	Ectopic pregnancy Other (specify)				23d. Date of delive Month	ory Day Year
	quires that n signed b uld be deta	þ	Part II. Other significant conditions con	tributing to death t	91	lting in the ur	iderlying cause give	en in Part I.			use contribute to the	ne cause of death? ably 4 □Unknown
Division of Vital Records,	The law re te has bee	Completed	MITRAL	RE	G-UR	GITA	TIUN		24a. Wa auto pen 1 🗆 Yes	ormed3/	prior to cor death?	psy findings available repletion of cause of
/ita	Physicien: Th r this certificate ral director, pag	Be C	25. Was case referred to medical examiner?						of Death (Check only		, 10103	2.00
of	Physic rthis o	1: To	1 Yes 2 No	ospital: 1 ☐ Inpati 28a. Date of Inji		ER/Outpatient 28b. Time of		4 🗀 1401	rsing Home 5 Aes)
o U	Attending I r death. ector: After by the funer	atior	1-Batural 5 Pending 2 Accident investigation	(Month, Da	ay Year)	Injury	28c. Injury Work M 1 🗆 Y	ং? Yes 2∐N			.,	
Divis	tal or Attences after death	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		jury - At hor tc. (Specify		eet, factory, office		28f. Location City or To	(Street ar own, State	nd Number or Rura e)	l Route Number,
	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	edical	29a. Certifier (Check only one) 1. Certifying Physical Examination (Check only one)	icien: To the best er: On the basis of and manner si	of examinati	vledge, death ion and/or inv	occurred at the timestigation, in my of	ne, date and pinion, deat	d place, and due to the h occurred at the time	cause(s , date and) and manner as st d place, and due to	ated. the cause(s)
	To T CO E	Σ	29b. Signature and title of certifier	11	IX		29c. License	7:- 0		10	ite signed (Month, I	Jay, Year)
7	11		50. Name and address of person who co	apleted cause of	death (Item	23a) (Type I	Print)	35%	U	/	1110	<i></i>
5	H-1	1	JOHN Rece	229	11 .	Jeffer	ram Bi	VD	SMITHS,	BUNG	- MA	21783
	Sta Registr		31. Date filed (Month OCT 20) 20	04 32. Project	rar's Signat	O. A.	resh		SM/Ms,			

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** Irene Kallis October 12 2004 12:30 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Genesis Eldercare Spa Creek Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 M 200 88 4. 1916 Cyprus 213-34-5806 Jan. Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10b. County 10c. City. Town or Location or 28a-f show the Medical Examiner must be notified at 1√2Yes 2 No Annapolis Maryland Anne Arundel Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9 German Street 21401 U.S.A. items 23a death v Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes XXNo Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat", or item any injury or other traumatic avent, the Mudical Ferrica Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Specify Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laundry Worker US Naval Academy 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Kallis Moshovos Petroula Moshovos 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Tom Kallis/nephew Severna Park, MD 43 Sequoia Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 \$\overline{\o Demetrios Cemetery 10/15/04 Annapolis, MD * 4 □Donation 5 □Other (Specify) 21. Signature of Funeral Lervice Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pight jargren **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospitel or Attanding Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) P.O. Box 68760, the attending physicien Physician/Medicai the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ò in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Sho Medical Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of our ifier 032136 1011312004 who impleted cause of death (Item 23a) (Type, Print) 30. Name and address of person 2108 Didmuh Brivo Clash, MD 21619 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 4 200 OCT 1 Registrar

Physicia

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State of Maryland / Department of Health and Mental Hygiefel 0 4 3	14	-

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Baltimore, Maryland 21215-0036	2	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23e or 28e-f show eny injury or other trearmetic event. If a Marical Examination at the marillard at once.	Funeral Director	Exami

Physician /Medical Examiner

To the Hospitel or Attending Phyeicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	1- For Unpend Item 23a, 27, 2 Registrar	oa-r per i	Certifica	te of D	eath Ca	2. Date of D	-).	3. Time of Death		
ian	1. Decedent's Name (First, Middle, Last)							Ž, 2ď04	2100P. M		
ical	Attila Eugene Kovacs 4a. Facility Name (If not institution, give street and number	oer)	4b. Cit	v. Town. or Lo	ocation of Dea			. County of Deat	h		
ner	Sacred Heart Hospital		Cumi	berlan	d			llegany			
	220-60-7096 1₽ M 2□F	Age (In yrs. last birth	(rs. Months		f Under 24 Hr Hours Mir				hplace (State or Foreign nuntry) MONY		
	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location						10d. Inside City Limits		
ō	Maryland Allegany	Franthura							1 ☐ Yes 2 🛣 No		
ect	40a Chant and Number	Frostburg		Zip Code			10g. Ci	tizen of What Co	untry?		
Funeral Director	10129 Boston Stree	I, N.W.	21:	532-			U.S.A				
ner	11. Marital Status 12. Was Deced	ent Ever in U.S. es?	13. Was Dec	edent of Hisp	anic Origin? (Mexican, Pue	Specify Yes or Norto Rican, etc.)	0-	14. Race - Ame Black, White			
Fu	1 Never Married 2 Married 1 Types 2	□No		_	Specify:			Specify:			
d by	3 ☐ Widowed 4 ☐ Divorced Year or Date	as: 1973 - 79					White 16b. Kind of Business/Industry				
Completed	15. Decedent's Education (Specify only highest grade completed)	16a. I	Decedent's Us (Give kind of v life. DO NOT	vork done dui	on ring most of w	orking	16b. K	(ind of Business/	Industry		
ם	Elementary/Secondary (0-12) College (1-4	or 5+)	acher	use reureu)			boa	rd of educa	rtion		
ပိ	12 8 17. Father's Name (First, Middle, Last)	lec	ucher	1	8. Mother's Na	ame (First, Middle			JIOH		
Be							le, Maiden Sumame)				
1º	Eugene Kovacs 19a. Informant's Name/Relationship (Type, Print)	10h	Mailing Addro		Elfrieda I	Rural Route Numb	or City	or Town State 2	Zin Code)		
	Melinda Kovacs wife		29 Boston		W	stburg		Maryland	21532-		
	20a. Method of Disposition	20b. Place of	Disposition (N	lame of	110	Date		ocation - City or			
	1 Burial 2 □ Cremation 3 □ Removal from St '4 □ Donation 5 □ Other (Specify)	ate Maryland	v, crematory`o Veteran's	_ ' . '	28	-Oct-2004	Flints	tone A	Maryland		
	21. Signature of Funeral Service Licensee	1		and Address		Frost Ave.,	C., 1 t-	MD /	01.500		
ledical Examiner	resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										
Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown 23d. Date of death 1 Live birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of death Month Month 1							ivery Day Year			
ed by Pl	Part II. Other significant conditions contributing to dea	th but not resulting in	the underlying	g cause given	in Part I.		tobacco Yes 2		the cause of death?		
omplet						24a. Was auto pen 1 X Yes		prior to death?	itopsy findings available completion of cause of 2 \(\subsetential \text{No} \)		
Be (25. Was case referred to medical examiner?			2	26. Place of D	eath (Check only	one)				
2	1X Yes 2 No Hospital: 1 □ Ing	oatient 2 XER/Out			4 Nursing	Home 5 Res			cify)		
on:	27. Manner of Death 28a. Date of (Month,		njury	28c. Injury a Work?		28d. Describe	how inju	ry occurred			
cati	2 Accident investigation 3 Suicide 6 Could not be			1 TYE	s 2 X No	unknow		/N - 1 - 5			
ertifi	4 Homicide determined building	f Injury - At home, far g, etc. <i>(Specify)</i> at home	m, street, fact	ory, office		28f. Location City or To	Street al wn, State	19129 B Carvland	oston St.,		
Medical Certification:	29a. Certifier (Check only one) 1 Certifying Physician: To the base and manner	est of my knowledge, is of examination and	, death occurre Vor investigati	ed at the time, on, in my opin	, date and place nion, death occ	ce, and due to the	cause(s) and manner as	stated.		
Me	29b. Signature and title of certifier O.C.M.E. 29c. License number O.C.M.E.								, 2004		
30. Name and address of person of completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, M. Jak. M. Tipus, M.D.							e, Mary	land 21201			
ate rar	31. Date filed (Month, Day, Year) 32. Rec	Astrar's Signature	B A	park							

Registrar

Physician /Medical Examiner 4 Euneral Director 1 DI Lector 1 DI Lector 1 DI Lector 1	Registrar Donald, L, a. Fecility Name (If not institution, give s Holy (105%) Ho Social Security Number 6. Sex 1058-26-7197 Jsual Residence of Decedent 10a. State 10b. County Maryland Montgome 10e. Street and Number	7. Age (In yrs. I	last birthday)		r Location of Dea	2. Date of De Month i O	Day	Year 2001	3. Time of Death
Examiner 4 Funeral 5 Director 0	Holy (ross Holds) Social Security Number 5. Sex 12 558-26-7197 Usual Residence of Decedent 10a. State 10b. County Maryland Montgome	treet and number) The land T	last birthday)	Silver	r Location of Dea	ith	-	County of Do	
Director C	12 158-26-7197	M 2□F 72		If Under 1 Year	Spring	s. 8. Date of Bir	th	Montgo	
usi be notified at	Maryland Montgome			Months Days	Hours Mi		y, Year)	_ C	W York
usibe not usibe not rai Direc	0e. Street and Number	ry Ro	y, Town or Lo						10d. Inside City Limi 1 ☐ Yes 2 🖾 I
23a				10f. Zip Code			10g. Citiz	en of What C	ountry?
	4405 Hallet Str	eet		20853	3		J	JSA	
al', or Items 23s Examinat must by Funeral	1. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U. Armed Forces? □ Yes 2 □ No If Yes, Give Year or Dates:	1	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 🛣 No	lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No into Rican, etc.)		4. Race - Am Black, Whi Specify: W	
ygene. Net than "naturalized to the Medical to the	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of w	orking	16b. Kin	nd of Business	/Industry
Con Con	12		Pai	rts Drive				comobil	е
arkad oth atic avant To Be	17. Father's Name (First, Middle, Last) Henry Godfrey Kir	schenmann, Sr	·.			ame <i>(First, Middl</i> e elen Gel		Sumame)	
rauma	19a. Informant's Name/Relationship (Type		1	ng Address (Street					
t: If item 2	Shirley S. Kirsche Oa. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	20b. P	lace of Dispo emetery cren Drt Lir	Hallet S sition (Name of natory or other place COIn	Oct	Rockville Date ober 16 2004	20c. Loc	cation - City or	Town, State
Importan any injuri once.	21. Signature of Funeral Service License	200		Name and Addre	ss of Facility. Collin	s Funeral	1 Hom	e Inc.	Maryland
nn and rial-transit ransit Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or a) consequence to (or as a consequence to (or a) consequence to (or a) consequence to (or a	uence of):	Inforc	1.071				2 & Oay
ittending phy for use as the lan/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \) No 9 \(\text{Unknown} \)	ac. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)	,		2	3d. Date of de Month	livery Day Year
be det by P	Part II. Other significant conditions con	tributing to death but not resu	ulting in the ur	nderlying cause giv	en in Part I.		obacco us Yes 2 🗆		o the cause of death? robably 4 Kunkno
certificate has been si						24a. Was auto perfo 1 \(\text{Yes}		prior to death?	utopsy findings availa completion of cause 2 \(\text{\text{\text{No}}}\)
certificate	25. Was case referred to medical examiner?	ospital:		Oth		eath (Check only o			
al d	1 Yes 2 No '' 7. Manner of D ath 1 Natural 5 Pending 2 Accident investigation	28a. ate of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injur Wor	y at	Home 5 Resi 28d. Describe			ocify)
To the Funeral Director: After completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, str	eet, factory, office		28f. Location (City or To		l Number or R	ural Route Number,
he Funera pletely fille edical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medicel Examin	icien: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death tion and/or inv	occurred at the tirvestigation, in my o	ne, date and pla- pinion, death oc	ce, and due to the curred at the time,	cause(s) a date and	and manner a place, and due	s stated. e to the cause(s)
To the comp	29b. Signature and title of certifier	mD		29c. Licens		1390	29d. Date	signed (Moni	h, Day, Year)
3	30. Name and address of person who co	mpleted cause of death (Item	23a) (Type,	Print) est 6/e				mr	

State of Maryland / Department of Health and Mental Hygiene 34350 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** KRAM October 13, 2004 7:30A. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Hebrew Home of Greater Washington Montgomery Rockville If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Nov. 7, 1918 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1□M 2√2F 069-30-0172 85 Director Praszka, Poland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 'naturel', or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23a or 28a-f show any injury or other treumatic event, it a Medical Exercit errorant be notified at once. 1 ☐ Yes 2 √No McLean Virginia Fairfax Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5910 Chesterbook Road 22101 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Representative Bakery 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Abraham Urbach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Jacobson-Kram 5910 Chesterboork Rd. McLean, (son) Virginia 22101 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State Young Israel Mem.Park 10/17/2004 East Haven, Connecticut * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Donald V. Borgwardt Funeral Home, P.A.
4400 Powder Mill Road Beltsville, Maryland 20705 21. Signature of Funeral Service Licenses onald 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one has on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Division of Vital Records. P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: After or Attending 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel o within 24 hours aft To the Funeral Di 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 1808 MD Those De, Rockcully MD 2085 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6121 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 14 2004

State of Maryland / Department of Health and Mental Hygie Pen 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year)c+ 1015 Hilda H. Kuhn 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore City N/A Union Memorial Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) 1 ☐ M 2 🕱 F Days Hours Yrs. Oct 12, Director 215-18-1529 80 1923 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 7 is marked other than "naturel", or items 23a or 28e-f show treumatic event, the Madical Examiner must be notified at 10d. Inside City Limits 1XX es 2 □ No Director Maryland Carrol] Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 150 Lincoln Rd. 21157 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 27 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: à Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 1 and 2 should be filed w
 Health and Mental Hygier
 tem 27 is marked other th 0 Clerk Book Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Bernard Raymond Rickell Helen Josephine Lease

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 I Andrew J. Kuhn, Jr Husband 150 Lincoln Rd. Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pagas 1 nent of H ont: If ite 1 ☐ Burial 2 Macremation 3 ☐ Removal from State permit. Paga Department of Importent: If any Injury or once. ` 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Inc 10/13/04 Hampstead, MD 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA 21. Signature of Funeral Service Licenses 412 Washington Rd. Westminster, MD Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ascending Physician aortic a. Cuptured asce ue to (or as a consequence of): 20 disease or condition resulting in death) /Medical **Examiner** dissec tion unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be axecuted use as the burial-transit rpertension ue to (or as a consequence of) the attending physician Division of Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 X No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ certificate has baen signer rector, page 2 should be Completed 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq\text{Yes}\) 2 \(\subseteq\text{No}\) 24a. Was an autopsy performed? 1 X Yes 2 No To the Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 1 Nnpatient Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending death. investigation М 1 ☐ Yes 2 ☐ No after death 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20138 completed cause of death (Item 23a) (Type, Print) 30. Name and address of o N. Calvert St. Baltimore, 3333 rank 31. Date filed (Month. Day, Year) 32. Registar's Signature State Registrar 2004

		•	State of Maryland / Dep State of Maryland / Dep Registrar Ce		
	Physici	an	Decedent's Name (First, Middle, Last) Peggy Bradshaw Lohmeyer		2. Date of Death 3. Time of Death October 15 Yea 2004 0659 M
	/Medic Examin	- 15	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death Talbot
	Funeral		Memorial Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Easton If Under 1 Year If Under 24 Hrs.	
4	Director		212-26-1890 1 M 2 F 74 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 12/23/1929 Maryland
2	iath with the Maryland 8 23a or 28a-f show	ō	10a. State 10b. County 10c. City, Town or L MD Caroline Denton	ocation	10d. Inside City Limits 1 ☐ Yes 2 1 No
)	or 28a-l	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
-	₽ 23 ■		11069 Knife Box Road	21629	USA
) 980	in 72 hours after death 'n natural', or Items 23i	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto of 1 ☐ Yes 2 No Specify:	acify Yes or No-Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	within 72 ho ene. than *naturi he Medical I	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of workii DO NOT use retired)	ng 16b. Kind of Business/Industry
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and	2 should be tited withir and Mental Hygiene. Is marked other than eumatic event, the M	Be	17. Father's Name (First, Middle, Last)		(First, Middle, Maiden Sumame)
Z	should be ind Mental s marked o umatic eve	5	John Hargis Bradshaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mail		tevenson Bradshaw Il Route Number, City or Town, State, Zip Code)
	nd 2 salth an 27 is			9 Knife Box Road; I	
Baltimore,	permit. Pages 1 and 2 should Department of Health and Mer- Importent: If item 27 Is marke any injury or other treumatic <u>once</u> .		1 Aburial 2 Cremation 3 Hemoval from State	osition (Name of smatory or other place) Shore Vet.Cem 10/19	20c. Location - City or Town, State
Baltii			21. Signature of Funeral Service Licensee	2. Name and Address of Facility	9/04 Hurlock, MD ein Funeral Home, PA oro, MD 21639
4	Physician		23a. Párt 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	nter the mode of dying, such as cardiac o	
	eath certificate be executed attending physician and for use as the burial-transit	dical Examiner	resulting in death) Sequentially list conditions, if any, leading to ammediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		
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	requires that the een signed by th nould be detache		Part II. Other significant conditions contributing to death but not resulting in the t	ınderlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Tonknown
l Rec	The larate has	Completed			24a. Was an autopsy performed? 1 Yes 24No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 2 No
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death Other:	
on of	tte.	ıtlon: To	1	TIL 3 DOX 4 Nursing Hon	ne 5 Residence 6 Other (Specify) 28d. Describe how injury occurred
Divis	To the Hospitel or Attendit within 24 hours atter death. To the Funerel Director: A completely titled in by the fu	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	te Hospit 24 hours te Funere letely tille	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deal 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, a specification, in my opinion, death occurre	and due to the cause(s) and manner as stated. ed at the time, date and place, and due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
				D0053815	10/15/2004
155-			30, Name and address of person who completed cause of death (Item 23a) (Type, KORAH M. FULLIMOOD 9/2-D/	Print) MARKET STREET	DENTON MD 2/629
為	Sta Registr		31. Date filed (Month, Day, Year) OCT 1 9 2004 32 Registrar's Signature	and s	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav **Physician** Leonard Frederick Leyh October 14,2004 10:10 a^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Memorial Hospital Havre de Grace Harford 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 14,1927 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months 1⊠M 2□ F Days Hours 217-20-5273 77 Yrs Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "netural", or items 23s or 28s-1 show treumstic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Cecil Conowingo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 53 St. Judes Lane 21918 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 🔀 Married 1 Tyyes 2 □ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: If Yes, Give Year or Dates: WW II à White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry (Specify only highest grade completed) Central Atlantic College (1-4or 5+) Elementary/Secondary (0-12) Diesel Mechanic Aberdeen, Maryland Twelve Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental Frederic Leyh Clara Smoot 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) E. Virginia Leyh (wife) 53 St. Judes Lane, Conowingo, Maryland othar 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Pages nent of h permit. Pages
Department of
Importent: If it
any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Highview Memorial Gardens 10/18/04 ^¹ 4 □Donation 5 □ Other (Specify) Fallston, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ue to (r as a consequence of): lar Few_Hours /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, φ 1 ☐ Yes 2 1 Ho 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification; 28b. Time of 28d. Describe how injury occurred To the Hospitel or Attending After Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation rector: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29b. Signature and title of certifie. 29d. Date signed (Month, Day, Year) 30. Name and address of person who co cayse of death (Item 23a) (Type, Print) 31. Date filed (Month, Oay, Year) State 1 8 2004 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygie?

31,351

			1 - For State Registrar 1. Decedent's Name (First, Middle, Last)	State of Maryland			of Death	2. Date of	Reg. I		34334	
	Physic		Gilbert T.	Lynch				Octobe		2004	3. Time of Death 6:45 P M	
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	Funeral Director		1/0-03-6330	7. Age (In yrs. Ia	Yrs.	If Under 1 Months D		Min. 8. Date of (Month, Febru	Birth Day, Yea lary	9, 1917 9. Birthp	place (State or Foreign htry) PA	
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Mary	s 1 and 2 should f Health and Men item 27 is marke other treumatic	ľ	19a. Informant's Name/Relationship (Type							or Town, State, Zip	Code)	
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altimor	permit. Pages Department of H Importent: If ite any injury or of		1 ■ Burial 2 □ Cremation 3 □ Ro '4 □ Donation 5 □ Other (Specify)		ensbur ensbur em	atory or othe g Cath etery	olic Oc	t. 20,20	04 G	Location - City or To	, PA	
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			30. Name and address of person who con				B, Elli	Cm Mn	2/92	-/		
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1	16. 25.		23a. Part1. Enter the shock, or hear	ne disease, or co nt failure. List on	mplications y one caus	that caused e on each li	d the death. ne.	Do not ente	er the mode	of dying	, such as o	cardiac o	or respiratory ar	rest,		Approxim Interval B Onset and	etween
<u>ک</u>	Physician /Medical Examiner		Immediate Cause (disease or condition resulting in death)		a/	Ine	un	ani	<u>a</u>							day	2
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60,	cate be execul physician and the burial-trar		Sequentially list cor if any, leading to im cause. Enter Unide Cause (Disease or	iniury 📧	c	1	rhe	-el	Un	30	ne		Disc	A SAN	ER.	uca	
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o C		Ë	27. Manner of Death	1	28a.	Date of Inju (Month, Da		8b. Time of Injury		c. Injury Work		2	28d. Describe h	ow injury occur	red	,	
š	anding ath. or: Aft he fur	atio	1 ■Natural 2 Accident	5 Pending investigation	on 7	6/04	& 11	nknow	n M	1 □ Y	es 2X N	lo	in jure	fell &	thei	n was	onino
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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygena () 4 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 9:55 Рм Barbara Gale McKay October 21, 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 44285 Blake Creek Road Leonardtown Saint Marys If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🖺 F 49 Months Director 215-70-9157 January 18, 1955 Maryland Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10a State 10h County 10d. Inside City Limits in than "natural", or items 23a or 28a-f show the Modical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Saint Marys Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 44285 Blake Creek Road 20650 Funeral IISA permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural" or item an injury or other traumatic even. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 X Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced 16a Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Leonard Wheeler , Sr. 2 Agnes Cecelia Knott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roland Rea McKay / Husband 44285 Blake Creek Road, Leonardtown, Maryland 20650 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) October 26, 2004 tropolitan Crematory Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line ath. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) side with **Physician** mond /Medical Due to (or as a consequence of) Examiner Prumbr Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) _ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Ses 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 0400 11/0 1 Yes 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26 Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Cther: 4 ☐ Nursing Home 1 Yes 2 XVo 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury after death. Director: Af 1 TYes 2 □No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours 29a. Certifier cal 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier (0/ 22/04-DO0 32651 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rita Jhaveri, M.D. 22335 Exploration Park Drive, Suite 1035, Lexington Park, Maryland 20653 31. Date filed (Month, Day, Year) 32. Begistrar's Signature

State

Registrar

donelle

State of Maryland / Department of Health and Mental Hygiene 0 14 Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician 20, 2004 5:30 a.m October Oliver Mills Stephen /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's Great Mills Bayside Care Center If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 X M 2 □ F Yrs. 1915 Mary land 14, 89 **Director** 218-30-4627 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10a. State 10b. County in than "neturel", or items 23s or 28s-f show the Medical Examinat must be indiffed at 1 TYes 2 No Lexington Park St. Mary's Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ឨ 20653 United States 21412 Great Mills Road Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: Baltimore, Maryland 21215-0036 **Black** þ 3 ■ Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) other than Agriculture Farmer permit. Pages 1 and 2 should be filed v
Department of Health and Montal Hygiei
Important: if item 27 is marked other it
any injury or other treumatic event, Ita
once. 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Della Ann Thomas James Edward Mills ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 23960 Budd's Creek Road, Clements, Maryland 20624 Rose Scriber / Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State Charles Memorial Gdns, 10-23-2004 Leonardtown, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650-0279 Edward N. Brinsfield, Jr. M00052 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final moule Physician disease or condition resulting in death) /Medical Due to (or as a comequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit physician and Due to (or as a consequence of): Box 68760, Physician/Medical the use as IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Dav Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f o 9 Unknown Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2.2 No or Attending Physicien: after death. I Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check on one Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 28c. Injury at Work? 28d. Describe how injury occurred funeral 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 - Homicide within 24 hours a 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier mes ause of death (Item 23a) (Type, Print) ss of person who completed 30. Name and add M.D., 24035 Three Notch Road, Hollywood, Maryland 20636 Patrick Jarboe, 32 Registrar's Signature 31. Date filed Month, Day, Year) State 2 1 2004 Registrar

Brandon Martin 04-6921 DOS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			1- State of Maryland / Department of Health and W Registrar Unpend Item 23a&27 per me G837 11-29-04 tas Certificate of Death		3.1	34330
	Physicia		Decedent's Name (First, Middle, Last)	2. Date of Dea Month	ath Day Year	3. Time of Death
	/Medic		Brandon Wayne Martin	Octobe	r 25, 2004	1150 a M
	Examin		4a. Facility Name (If not institution, give street and number) Peninsula Regional Medical Center 4b. City, Town, or Location of Death Salisbury		4c. County of De Wicomio	
d	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 21 P-02-7709 6. Sex 1 Nage (In yrs. last birthday) 1 F Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day 5/09/	9. B (, Year)	irthplace (State or Foreign Country) arvland
\$			Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	37 0 37	1203 11	10d. Inside City Limits
	the Marylan 28e-f show nutitled at	tor	Maryland Wicomico Pittsville			1 Tes 2 X No
	vith the	Funeral Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What (Country?
	ath with s 23a or	E .	7380 Gumboro Rd., Apt. 4 21850	77 32	USA	
920	be filed within 72 hours after death with the Maryland la! Hyglene. d other than "natural", or Items 23a or 28e-f show avent. The Medical Exam har must be multised at	by	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼ Never Married 2 ☐ Married 1 ☐ Yes 2 ▼ No	ecity Yes of No- Rican, etc.)		nerican Indian, lite, etc. white
5-0	"natur	leted	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work iii	ing	16b. Kind of Busines	s/Industry
Maryland 21215-0036	d within 72 ho giene. ir than "natui the Medical	Completed	Elementary/Secondary (0-12) 12 College (1-4or 5+) Peli Clerk		Wal Mart	:
pui	be filed ntal Hygie of other event.	Be	17. Father's Name (First, Middle, Last) Richard Martin 18. Mother's Name Donna			
ıryle	2 should be fi and Mental H is marked of raumetic ever	스	Richard Martin Donna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura	Webs al Route Numbe		. Zip Code)
	ss 1 and 2 should b of Health and Ments 		Donna W. Martin/mother 7380 Gumboro RdA	pt.4,F	Pittsvill	e, MD 21850
Baltimore,	Pages 1 and of He		1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State			
Itim	# 문문를 .		'4 □ Donation 5 □ Other (Specify) Salisbury Crematory 1 21. Signature of Funeral Service Life nee 22. Name and Address of Facility			
Ba	Depa Impo any is		21. Signature of Funeral Service Livingee 22. Name and Address of Facility Holloway Funeral 501 Snow Hill Ro 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of	Home L.Sali	Professi Sburv.MD	onal Assoc
			shock, or heart failure. List only one cause on each line.	or respiratory ar	rest,	Approximate Interval Between Onset and Death
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	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Office of hydry			
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P.O. B	that the death ed by the atte detached for	Physician/N	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 5 ☐ Other (specify) 9 ☐ Unknown		Month	Day Year
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ord	v require been signal			1 🗆 Y		Probably 4 Unknown
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	ding Physician: The n. After this certificate his funeral director, page	o Be	25. Was case referred to medical examiner? 1 XYes 2 No 1 No Note: 1 Inpatient 2 FR/Outpatient 3 No Other: 4 Nursing Ho		ne) lence 6 □Other (St	necify)
n of	ding Phy n. After thi funeral (T ;uo	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 4 United States 1 Manual 5 Pending (Month, Day Year) 28b. Time of Injury Work?		now injury occurred	
Division	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendir completely filled in by the funeral director, page 2 should be detached for use	Certification;	2 Accident investigation M 1 Yes 2 No	28f. Location (S City or Tow	Street and Number or i vn, State)	Rural Route Number,
Ω	To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.)			
	the H hin 24 the Fi	Medical	one) and manner stated. 29b. Signature and tive of certifier		29d. Date signed (Mo	
	Vii To) ALAW M OCME		October 20	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street	et, Balt	cimore, Mar	ryland 21201
	Sta	ate	31. Date filed (Month, Pay Year) 2004 32. Registrar's Signature & Sparks			

			1 - For State Registrar	State of Marylan		artment of He tificate of L			evie ∩ ∩ rt	34333		
	Physici /Medic		Decedent's Name (First, Middle, La. WILLIAM FREDER	•	R.			2. Date of Death		3. Time of Death 4 11:44A M		
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death							ath		
	Funeral Director		213-10-2396	7	last birthday) Yrs.	FREDER If Under 1 Year Months Days	RICK If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, JAN 26	FREDERI Year) 9. Bi 1918	CK rthplace (State or Foreign ountry) MD		
Maryland ZIZ13-0030	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County MD FREDER		ty, Town or Lo					10d. Inside City Limits 1 ▼Yes 2 □ No		
	th with the 23a or 28a	Funeral Director	10e. Street and Number 990 WATERFORD	DRIVE		10f. Zip Code 21702	2	10	g. Citizen of What C	•		
	urs after dea at', or Items	by Funer	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No 1 9 If Yes, Give Year or Dates: 1 9 4 6	41-	Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2 ☑ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: W			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "naturat, or Items 23a or 28a-f show ampringury or other traumatic avant, if a Medical Evant met the notified at ance.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) The CORD T CATE FINCE NEED ACCORTS JOHNS									
	uld be filed a Aental Hygie rked othar tic avant, ti	To Be Co	12 17. Father's Name (First, Middle, Last, WILLIAM FREDER		1220		18. Mother's Nam	e (First, Middle, M	aiden Sumame)			
	and 2 sho saith and h n 27 is ma ar trauma		19a. Informant's Name/Relationship (KAREN JETT / I	••					City or Town, State,			
pallimore	Pages 1: ment of He ant: If Itan ury or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specif	Removal from State	cemetery, crer	sition (Name of natory or other place CK CREMA)		0c. Location - City o			
	permit Depart Import any inj		21. Signature of Juneral Service Lifter	M		Name and Address		HOME RNESVILI	JE, MD	20838		
	hysician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition ACUTE RENAL FAILURE									
	/Medical Examiner	-	resulting in death) Sequentially list conditions,	Due to (or as a conseq DEMENTIA A		YEARS						
1	and I-transit	Examiner	Sequentially list conditions, if any, teading to in inediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	HYPERTENSI c.	YEARS							
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DOX.	death cer e attendir d for use	Physician/Me	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown								
	The law requires that the site has been signed by the bage 2 should be detached.	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ATRIAL FLUTTER, CORONARY ARTERY DISEASE 1 Yes 2 No 3 Pr									
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II OI VICAL		Certification; To Be C	CELLUITIS 25. Was case referred to medical	f			26. Place of Deat	perform 1 Yes 2	▼No 1 □ Yes	2 No		
	ng Phys fter this meral dii		examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (S. 1) 27. Many r of Death 1 Autural 5 Pending (Month, Day Year) 2 Accident Investigation Note: 4 Nursing Home 5 Residence 6 Other (S. 1) 28b. Time of Injury Work? 1 Yes 2 No							rolly) Living relik		
DIVIS	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hosp within 24 hou To tha Funa completely fil	edical	29a. Certifier 1 Certifying Pt (Check only 2 Medicel Examone)	nysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, death ation and/or in	n occurred at the time vestigation, in my opi	e, date and place, inion, death occur	and due to the cau red at the time, dat	use(s) and manner a se and place, and du	s stated. e to the cause(s)		
	To the within To the Comp	Me	29b. Signature and title of oprifier	Reilly	MI	29c. License D5474			d. Date signed (Monitorial CTOBER 1			
	8		30. Name and address of person who ALLEN REILLY,				D_1 ₽¤	EDERTOR	, MD 21	7.0.1		
Г	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	4 Ann	- · · · · · ·	LIBERTOR	<u> </u>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygion [] Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 3:35 PM Marko Mila October 11, Mini 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 8. Date of Birth (Month, Day, Yea If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Jan 1, Director 219-59-8700 1930 Sudan Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23a or 28a-f show the Medical Examinar must be notified at MD Takoma Park 1 ☐ Yes 2 X No Montgomery Direct 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 6282 Red Top Road #201 20912 Sudan Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No 1 ☐ Yes 2 No Specify: Black If Yes, Give Year or Dates: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4or 5+) Sudan Government Veterinarian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental Mini Mila Kade Mila item 27 Is marke other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Moubla, Wife 6282 Red Top Road #201 Takoma Park, MD 20912 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages
Department of H
Importent: If ite
any injury or of 1XX Burial 2 Cremation 3 Removal from State Fairfax Memorial Park 10/16/2004 Fairfax, Virginia 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility FairfaX Memorial Funeral Home 21. Signature of Funeral Service License 19902 Braddock Rd. Fairfax, VA 22032 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) arcinoma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 autopsy certificate 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ this 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D18895

CR (3)

Division of Vital Records, P.O. Box 68760,

altimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

MOBARAK KAR
31. Date filed (Month, Day, Year)

OCT 1 5 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KARIM, 7610 CARROLL AVE, STE340, TAKOMA PARK, MD

(ear)
Registrar's Signature

(2004)

ORIGINAL

			1 - For State Registrar	State of Marylan		artment of H tificate of I			giene Reg. No.	004	34361
	Physicia	an	1. Decedent's Name (First, Middle, Last)	.1 1 11 0-				2. Date of Dea	Day	200 Year	3. Time of Death
	/Medic	al	Lore Elizabeth Ru 4a. Facility Name (If not institution, give st.		grans	4b City Town o	Location of Death	October		2004 County of Death	5:00 A. M
	Examin	er	Potomac Valley Nu			Rockvill		•	Montgomery		
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birt (Month, Da Jan • 28	h	9 Birtho	olace (State or Foreign
	Director		027-30-0706 Usual Residence of Decedent	7 7				5411.20	,1750	, , , ,	
1	how		10a. State 10b. County	10c. City	y, Town or Lo	cation				1	0d. Inside City Limits
ž	8e-fs	cto	Md. Montgome	ery	Rockv						1 ² Yes 2 □ No
	with u	Funeral Director	10e. Street and Number 1235 Potomac Valle	ev Road		10f. Zip Code	0850		10g. Citiz	en of What Cour USA	itry?
	ms 23	nera		2. Was Decedent Ever in U.	S. 13.	Was Decedent of H		pecify Yes or No	- 1	4. Race · Americ	
2	permit. Pages 1 and 2 should be filed within 72 hours after death with free maryanu Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Beginner if it file and 18 marked other then "neturel", or items 23e or 28e-f show eny injury or other treumatic event. The Medical Examination at the motified at once.	by Fur	1 Never Married 2 Married 3 Widowed 4 Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:	o Rican, etc.)		Black, White, Specify: Whi	
3	eture ical E		15. Decedent's Educa	ation	16a. Dece	dent's Usual Occup	ation	tina	16b. Kin	d of Business/In	
7	n" ner n" Ned	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done of NOT use retired	during most of wor	KITI'S		O II	
7	Hygier Hygier Ther th	Col	17. Father's Name (First, Middle, Last)	5 +	Home	maker	18. Mother's Nan	ne (First, Middle,	Maiden S	Own Hom Sumame) Ann	
ב ב	d be n ental h ked of c ever	To Be	Ernst Albert Mell	in			Martha E				
֝֟֝֟֝֟֝֟֝֟֝ <u>֚</u>	should Mind Mind Mind Mind Mind Mind Mind Min	1	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailir	ng Address (Street					
ž :	and 2 raith a 127 is er tre		Mark E. Sagrans/S	on	1225	New Hamp	shire AV	e.,NW #1			
20 .	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	emetery, crei	sition (Name of natory or other plac	1000	Date 14,		cation - City or To	
	riment riment right:		'4 □Donation 5 □ Other (Specify)	~ ~		ek Cemete				shington	n, DC
<u>8</u>	Depar Impo eny ir		21. Signature of Funeral Service Licenses	to I		2. Name and Addre					20007
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the deatle cause on each line.						,	Approximate Interval Between
ı	nysician		Immediate Cause (Final disease or condition	Malnutritic							Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):	****					
		e	Sequentially list conditions, it any leading to him solution cause. Enter Underlying Cause (Disease or injury	Advanced Co		al Cance	r				
	cuted nd ransit	Examiner	that initiated events — C								
Ď,	certificate be executed ding physician and use as the burial-transit		resulting in death) Last	Due to (or as a conseq	uence of);						
94/00,	cate b physic s the b	edical	d.							:	
XOD	nding nding use a:		IF FEMALE: 23 23b. Was decedent pregnant 23	c. If yes, outcome of pregna		75-4			2	3d. Date of delive	ery
	w requires that the death certifueers signed by the attending should be detached for use a	Physician/M	in the past 12 months? 1 ☐ Yes 2 🎛 No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown		Ectopic pregnancy Other (specify)	·			Month	Day Year
۲	requires that the een signed by th nould be detache		9 ☐ Unknown Part II. Other significant conditions cont		ulting in the u	nderlying cause gry	en in Part I.	23e. Did t	obacco us	se contribute to the	ne cause of death?
ďs,	signe signe	d by	Chronic Anemia, Co	-	-				Yes 2∑		pably 4 Unknown
	law requas been 2 shoul	iete						24a. Was		24b. Were auto	psy findings available
r	o - o	Completed						autor perfo	rmed?	prior to co death? 1 ☐ Yes	mpletion of cause of 2□ No
	ilcien: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?					ath (Check only o	ne)		
0 10	Physicien: this certific ral director,	2	1 □ Yes 2 汉 No	ospital: 1 Inpatient 2	-		er: 4 X Nursing H				y)
_	une une	tion:	27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor	y at k? Yes 2 □ No	28d. Describe I	now injury	occurred	
DIVISION	Attending or death.	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, st			28f. Location (: City or To		Number or Rura	I Route Number,
5	itelol urs afte rel Dii										
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fi	edical		ician: To the best of my kno er: On the basis of examina and manner stated.							
	To the within To the comple	Me	29b. Signature and title of certifier	0		29c. Licens	e number		29d. Date	signed (Month,	Day, Year)
•	ì		1100	tu.		D60	036		Octo	ber 11,	2004
	1		30. Name and address of person who cor			Print)					
			Mahmoud Doski, M. 31. Date filed (Month, Day, Year)	D., 1299 Lam		Dr., Sil	ver Spri	ng, MD.	2090	2	
	Sta Registr		OCT 1 / 200		19	Louis					

State of Maryland / Department of Health and Mental Hygie [] [] 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** MONTERE 11:57A M MBERL JUMIN 0 OL 07 /Medical 4a, Facility Name (If not institution, give street and number)
SHADY GROVE ADVENT 4c. County of Death City, Town, or Location of Death Examiner KOCKVILLE, MARYLAND ADVENTIST MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Yrs. 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1 ☐ M 2 💢 F MARYLAND NONE Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r then "naturel", or Items 23e or 28a-f ehow the Medical Examinational be notified at 1 ☑ Yes 2 ☐ No MD Director Rockville Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1001 Rockville Pike, Apt. 1211 20852 U.S.A. filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Asian þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Infant Infant 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be Department of Health and Mental Importent: If item 27 Is marked o Josef Monterey Leah G. Enriquez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1001 Rockville Pike, Apt. 1211, Rockville, MD 20852 Josef Monterey, Father 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ¹ 4 □ Donation 5 □ Other (Specify) 10/13/2004 Germantown, Maryland All Souls Cemetery 21. Signature of Furje al Service Licensee 22. Name and Address of Facility Simple Tribute any 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1040 Rockville Pike, Rockville, Maryland 20852 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician pontaneous /Medical Die to (or as a consequence of): Examiner Oue to (or as a consequence of): Sequentially list conditions, if any, learning to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner transit. and Due to (or as a consequence of): the attending physician a hed for use as the burial-Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant lor. 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by be 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 Jas 2 No 1 🗆 Yes 1 Yes the Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 □ No Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 2 ER/Outpatient 3□ DOA this Manner of Death 28d. Describe how injury occurred Injury at Work? Certification: After Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No investigation death. within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of gertifier 29c. License number ese of person who completed cause of death (Item 23a) (Type, Print) Gaithersburg, MD 208 Johnson 507 N. Frederi Janice 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 14 2004 Registrar

DHMH 17 Rev 1/2001

2. Date of Death

3. Time of Death

Physician

1. Decedent's Name (First, Middle, Last)

Division of Vital Records, P.O. Box 68760 this r death. Director:

12, VIOLET V. MORRTS OCT. 2004 11:20 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner KENSINGTON NURSING & REHAB. CTR. KENSINGTON MONTGOMERY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗷 F Months Days Hours Min Director 232-50-9079 87 JAN. 28, 1917 VIRGINIA Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other then "natural", or itema 23a or 28e-1 show traumatic event, the Medical Examinar must be notified at 1 Yes 2 No MONTGOMERY GARRETT PARK Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10902 RALEIGH AVE. 20896 Funeral U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: δ Specify: 3 □ Widowed 4 □ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE HOME 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be f Department of Health and Mental F mportant: If Item 27 is marked of ٩ **STEPHEN** KELEMEN IRENE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AGENBROAD/DAUGHTER TEAN. BOX 291, GARRETT PARK, MD. 20896 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injuryor CHAMBERS CREMATORY 10-14-04 RIVERDALE, MD. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A Combusal M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical * CORONARY HEART DISTAGE WITH YEAR S Examiner Due to (or as a consequence of): Examiner ISCHEMIC CARDIOMYOPATHY led by the attending physician and detached for use as the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the ceuse of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 2 NO 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 2 NO 1 ☐ Yes 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours e 1 Certifying Physicien: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 009834 Operlace 10 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 3720 FARFAGOT AVE KENSINGTON, MY ZORGE ROSENBAUM BARRY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2004

DHMH 16 Rev 6/95

			1 - State Amend I			per pl	ny G84	rtificate of	Death				
	Physici	an	Decedent's Name (First,		illiam Lo	ωσ Ma	ctin			2. Date of Dea Month Octobe	Day	.3 2004	3. Time of Death
Sales Control	/Medic	- 6	4a. Facility Name (If not ins				эсші	4h City Town	or Location of De		-	County of Death	6:00 A M
1.0	Examir	er	3004 North F						ott City			Howard	
F	uneral		5. Social Security Number	6. S	ex 7. Ag	e (In yrs. la	ast birthday)	If Under 1 Yea	r If Under 24 H	rs. 8. Date of Birt	 h	9. Birtho	lece (State or Foreign
The second	rector		215 44 4008	1	⊠ M 2□F	87	Yrs.	Months Days	s Hours Mi	in. (Month, Day March	28,1	.917 Was	hington DC
pur	*		Usual Residence of Deceder 10a. State 10b. C			10c. City	, Town or Lo	ncation				1	0d. Inside City Limits
Aaryla	oho .	ō		oward				City				,	1 ☐ Yes 2 🛣 No
the A	28a-	Director	10e. Street and Number	Oward	L	LI	TICOL	10f. Zip Code	· · · · ·		10a. Citi	izen of What Coun	try?
with	3a or	ā	3004 North F	idae	Road #306			21043			-	ited Sta	
5-0036 72 hours after death with the Maryland	ms 2	Funerai	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.S	S. 13.			(Specify Yes or No- erto Rican, etc.)		14. Race - Americ	an Indian,
afte Q	giene. ir than "naturel", or ltems 23a or 28a-f ehow the Medical Examination into the multified at		1 Never Married 2		1⊠Yes 2□ If Yes, Give	No	1	1 ☐ Yes 2 🔀 No		eno nican, etc.)		Black, White, Specify:	etc.
DOC:	urel.	d by	3 ₩Widowed 4 □ Div		Year or Dates:	1943-	45					Whi	
215-0036 ithin 72 hours af	natica	Completed	(Specify only	highest gra	de completed)		16a. Dece (Give	dent's Usual Occu kind of work don- DO NOT use retir	ipation e during most of w ed)	vorking	16b. Ki	nd of Business/Inc	dustry
within iene.	Trans.	шо	Elementary/Secondary (0	1-12)	College (1-4or	5+)				tive Asst	ਸ਼	ederal C	overment
Hygin	othe	BeC	17. Father's Name (First, M	iddle, Last)			1 01 00	ALICE TRE		ame (First, Middle,			OVELINETIC
ld be	marked matic ev	ToB	Mark Mastin						Eva Lov	<i>v</i> e			
Maryland 21 Id 2 should be filed with and Mental Hygier	e me		19a. Informant's Name/Rei	ationship (Type, Print)		19b. Maili	ng Address (Stree	et and Number or	Rural Route Numbe	r, City o	r Town, State, Zip	Code)
	Item 27 other tr		Marie M. New	man/D	aughter		2910	Mount Sr	now Court	Ellicot			
Baltimore, Dermit. Peges 1 at Department of Hea	-		20a. Method of Disposition 1 ☐Burial 2 ☐ Crem	ation 3 🗆	Removal from State			sition (Name of matory or other pl		Date		cation - City or To	
Saltim Permit. Peg Department	rtent		`4 □Donation 5 □Ot					Heaven (-15-2004	Whe	aton, Ma	ryland
Gal	Importent: It any Injury o once.		21. Signature of Funeral Se	Price Licer	= -(7)(()	71044							ly FH Inc.
			23a. Pert1. Enter the disea	se, or com	olications that caused	the death				a Pike El		tt City,	Approximate
01-		i	23a. Pert1. Enter the disea shock, or heart failure Immediete Cause (Final	. List only	one cause on each li	Ma1	ignant	Arrhyth	mia				Interval Between Onset and Death
	sician edical		disease or condition resulting in death)	-	aDue to (or as	3 00059011	ence of):	GAR					
Exa	miner			- 1	Congest			ailure					
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cuted	nd transi	Examiner	that initiated events	1	c								
Č,	ien a urial-		resulting in death) Last		Due to (or as	a consequ	ence of):						
. BOX 68 / 60, death certificate be executed	ng physicien and as the burial-transit	Medical			d								
X certific	anding I use as		IF FEMALE:		23c. If yes, outcome	of pregnar	ncv						
Bath ce	o th	cian	23b. Was decedent pregna in the past 12 months		1☐Live birth 4☐Pregnant at	2 Fetal	death 3[Ectopic pregnand Other (specify)	су		2	23d. Date of delive Month	ry Day Year
r is is	ed by the a	Physician/	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9□ Unknown			2 - 11101 (0,0001)/ 2					
	igned b	by PI	Part II. Other significant co	nditions of	entributing to death b	ut not resu	lting in the u	nderlying cause g	iven in Part I.	23e. Did to	bacco u	se contribute to th	e cause of death?
Hecords, he law requires t	been sig should b	edt	Corre	TIVE	horr -	10,10	-			1 U Y	es 2[□No 3 □ Proba	ably 4 Onknown
O ×	2 sho	Completed								24a. Was a		24b. Were autop	psy findings available appletion of cause of
T 2	page 2	E								autop:	med?	death?	2□ No
VITAI	certificate irector, pag	Be (25. Was case referred to m examiner?	edical					26. Place of D	eath (Check only or			
OT VITA Physician:	this co	2	1 ☐ Yes 2½ No		Hospital: 1 Inpalie		R/Outpatier	1 3LI DOA		Home 5 ☐ Resid	ence 6	Other (Specify)
	After t funera	ion:		ending	28a. Date of Inju (Month, Da	гу у Үөөг)	28b. Time of Injury	W		28d. Describe h	ow injury	occurred	
VISION Attending r death.	rector: by the f	icat	3 ☐ Suicide 6 ☐ C	ould not be		uni - At hor	ma farm str		Yes 2 No	29f Logation /C	troot on	d Number of Dural	Douts Mumber
# 5	2.5	Certification;	4 Homicide	etermined	building, et	c. (Specify)) ann, str	eet, factory, office	1	City or Tow	n, State)	d Number or Rural	Houte Number,
Hospitel	filled		29a. Certifier 1 🔏 Ce	rtifying Ph	ysician: To the best	of my know	vledge, deatl	occurred at the t	me. date and place	ce, and due to the c	ause(s)	and manner as sta	ated
19 Ho.	To the Funeral C completely filled	edicai	(Check only 2 Me one)	dical Exam	niner: On the basis o and manner st	f examinati	on and/or in	estigation, in my	opinion, death oc	curred at the time, d	ate and	place, and due to	the cause(s)
To the within 2	To th comp	×	29b. Signature and little of o	ertifier				29c. Licen	se number	2	9d. Date	signed (Month, L	Day, Year)
			Je to	ele,	110			0.	22 5 4	7	Octo	ober 14,	2004
0,2	`		30. Name and address of p	erson who	/ //	leath (Item	23а) (Туре,						
100			St. Date (" - d At . ii . ii	1 M	GOC 11	05/	C:416	FST VAD	17 10	La 60 M	17/	91/ 210	144
-	Sta Registr		31. Date filed (Month, Day,		32. Registr	ars Signati	ly A						
	7 Rev 1/2					-	19	A Charles		<u> </u>			

			For State Registrar	State of Ma	ryland / De	partment of F ertificate of	lealth and <i>Death</i>	Mental Hygi	e2004	34366
			1. Decedent's Name (First, Middle, La	st)				2. Date of Death Month	n Day Ye	3. Time of Death
	Physicia /Medic		MARIA		NOWICKI			October	13, 2004	3:30 A M
1	Examin		4a. Facility Name (If not institution, giv			4b. City, Town, o	r Location of Dea	ath	4c. County of D	
		6	Frederick Memo		tal (In yrs. last birthda	Frederi		s. 8. Date of Birth	Freder	
	Funeral Director			1 ☐ M 2 🖾 F	94 Yrs.	Months Days	Hours Mir	. (Month, Day,		Birthplace (State or Foreign Country)
	ט		Usual Residence of Decedent				<u> </u>	Mar.7,	1310 1	Russia
	show	<u>_</u>	10a. State 10b. County MD Montgoi	nerv	10c. City, Town or Bethe					10d. Inside City Limits 1 ☐ Yes 2 X No
	he M	ectc	10e. Street and Number		5000	10f. Zip Code		10	g. Citizen of What	
	23a or 2	Funeral Director	7505 Democracy	Blvd.Uni	t A131	208	17	10	USA	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "neturel", or Items 23e or 28e-f show any injury or other traumatic avant. If a Medical Examinet must be multified at once.	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:		3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No- irto Rican, etc.)		American Indian, White, etc. White
Maryland 21215-0036	in 72 ho n "netur Apoleal I	Completed	15. Decedent's E (Specify only highest gra	ade completed)	(Gi	cedent's Usual Occup ve kind of work done . DO NOT use retired	durina most of w	orking 1	6b. Kind of Busine	ess/Industry
212	d with giene.	mo	Elementary/Secondary (0-12)	College (1-4or 5- 4) I	nterpret	er		Publis	hing Co.
2	al Hygard other	ВеС	17. Father's Name (First, Middle, Last)	lad .			ame (First, Middle, M	laiden Sumame)	
yla	ould b Ment marked	7	unknown				unkno			
ă Z	d 2 sh th and th and 27 is rr traurr		19a. Informant's Name/Relationship (Laura Gilley/I	* * * * * * * * * * * * * * * * * * * *						ethesda,Md
altimore,	iges 1 an nt of Heal if item 2 or other		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □		20b. Place of Dis	position (Name of rematory or other place of the control of the co	(a)	Date 2	Oc. Location - City Jackson	or Town, State
altin	epartmer epartmer aportant ny injury		4 □ Donation 5 □ Other (Special 21. Signature Funeral Service Lice	HA			1			ICE, P. A. ing, Md20910
m	70 E % 9		Willy W	Gunlor	the death Death	9241 Col	umbia I	Blvd.Sil	ver Spr	
	Pnysician		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition					ac or respiratory arre	st,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):	al Faile	ti			1ml60
		ner	Sequentially list conditions, it as y, loading to immediate cause. Enter Underlying Cause (Disease or injury	b	consequence of):	, ,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
	ecuted and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	consequence of):	- ···				
8760,	icate be executed physician and s the burial-transit	dical E		. d.	consequence or).					
9	rtificat ng phy as the	Medic	IE EENALE.							
Вох	The law requires that the death certific ate has been signed by the attending p bage 2 should be delached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2	2 🗍 Fetal death	3 □Ectopic pregnancy	,		23d. Date of Month	delivery Day Year
0	he dea the a	ysici	1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnant at t 9□ Unknown	ime of death	5 ☐ Other (specify) _				Day / Oal
Δ.	res that the de igned by the a be detached f	/ Ph	Part II. Other significant conditions	contributing to death bu	t not resulting in the	underlying cause giv	en in Part I.	23e. Did toba	acco use contribut	e to the cause of death?
rds	quires n sign ald be	d by	Dementra					1 🗆 Yes	s 2 ⁄2 No 3□	Probably 4 Unknown
Records,	aw require s been si 2 should b	Completed						24a. Was an	24b. Were	autopsy findings available to completion of cause of
æ	The lav	mo						autopsy perform	ed? death	to completion of cause of 1? /es 2 \sum No
Vital		Be C	25. Was case referred to medical examiner?	23.			26. Place of De	eath (Check only one		
Ž >	Physician: r this certifica ral director, I	To	1 Yes 2 No		nt 2 ER/Outpat	ient 3 DOA Oth	er: 4 Nursing	Home 5 Residen	ce 6 Other (S	Specify)
Division of	ding P h. After t funera		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time	/ Wor	k?	28d. Describe hov	v injury occurred	
isio	Attending or death. actor: After by the fune	lcat	2 Accident investigation 3 Suicide 6 Could not be	00 Place of Injur	ny - At home farm	M 1 street, factory, office	Yes 2 □ No	28f Location (Stre	eet and Number o	Rural Route Number,
2	of or Attence after death Director:	Certification:	4 Homicide determined	building, etc.	(Specify)	street, ractory, office		City or Town,	State)	Tital Tital Tunion,
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier 1 (Check only one) (Check only one)	nysician: To the best of miner: On the basis of and manner state	examination and/or	ath occurred at the tir investigation, in my o	ne, date and place pinion, death occ	ce, and due to the cau curred at the time, dat	use(s) and manner te and place, and c	r as stated. due to the cause(s)
	o the	Med	29b. Signature and title of certifier	and mainer stat		29c. Licens	e number	29	d. Date signed (M	onth, Day, Year)
))	9-1		D43	091		10-13-04	
	lo		30. Name and address of person who	-	ath (Item 23a) (Typ	e, Print)	e An	Frede	rich, Mi	91701
	Sta Registr		31. Date filed (Month, Day, Year) OCT 15 2	32. Registra	r's Signature	1	,	Frede		
*	negisti	uı	707	JUT PET	1	ROOCK				

			1 - For Stata Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of ertificate o	Health a	and Mental Hy	giezer	004	34367
	Physici		1. Decedent's Name (First, Middle, Last) Adah B. Ness					2. Date of De Month October	ath	2004 ^{Year}	3. Time of Death 12:10A. M
	/Medic Examin		4a. Facility Name (If not institution, give s Wilson Health Care		1		n, or Location o	f Death	4c. C	County of Dear	
	Funeral Director		501-16-0912	7. Ag	e (In yrs. last birthda 94 Yrs.	/) If Under 1 Ye Months Day		Min. 8. Date of Bin (Month, Da March	th ly, Year) 1, 19	9. Bin Co No	thplace (State or Foreign buntry) cth Dakota
	Aaryland f show	ō	Usual Residence of Decedent 10a. State 10b. County Marray Land		10c. City, Town or	ocation					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	a or 28a-	I Direct	Maryland Montgome 10e. Street and Number 301 Russell Avenue		Galtin	10f. Zip Code 208			-	en of What Co	ountry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or itema 23a or 28a-f show appring the part in the marked other traumatic event, it is Marylaid Exant and rotal be indified at once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 Y If Yes, Give Year or Dates:		. Was Decedent of If Yes, specify C	uban, Mexican	gin? (Specify Yes or No , Puerto Rican, etc.)		4. Race - Ame Black, Whit Specify: V	
21215-0036	vithin 72 hou ne. han "natura hadical E	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5	(Giv	edent's Usual Occ e kind of work do DO NOT use ret	ne during most ired)			d of Business	Industry
Q 5	filed v Hygie other t	Be Co	17. Father's Name (First, Middle, Last)		Lice	ised prac		Nurse r's Name <i>(First, Middl</i> e,		edical Sumame)	
ylan	Mental Mental arked atic ev	To B	Ole Hofto			******	Marg	aret Rignas	tad		
Maryland	d 2 shotth and thand traum		19a. Informant's Name/Relationship (Ty) Darlene Griffin -	•				r or Rural Route Numbe , Frederick	-		Zip Code) 21701
Jre,	of Heal		20a. Method of Disposition		20b. Place of Dis			Date		ation - City or	Town, State
Baltimore,	i. Page tment tent: If tury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)		1				Frede	erick,	Maryland
Ba	Depar Impo		21. Signature of Funeral Service License 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or compli	ille to	line		ssumtow	n Pike, Fre	deri		yland 21702
	Pnysician		shock, or heart failure. List only or Immediate Cause (Final disease or condition	e cause on ach li	ne.		zymy, such as t	cardiac of respiratory at	11651,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of): hydrah	OA)		-			1 week
	ecuted ind transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause United Sequents, that initiated events resulting in death) Last	Due to (or as	a consequence of):	u					Iweeli
8760,	cate be executed physician and the burial-transit		o day		years						
.O. Box 6	that the death certifici ed by the attending pl detached for use as t	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregnal □ Other (specify)			23	Bd. Date of del Month	ivery Day Year
s, P	sign sign		Part II. Other significant conditions con	tributing to death b	ut not resulting in the	underlying cause	given in Part I.	23e. Did to			the cause of death?
Vital Record	The law ate has b page 2 s	Completed						24a. Was autop perfo 1 \(\text{Yes}			topsy findings available completion of cause of
	Physician: The l this certificate har ral director, page	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	nt 2 ER/Outpati	ent 3 DOA	Othor	of Death (Check only o		Other (Spe	nific)
ion of	ding Ph h. After th funeral		27. Manner of Death 1- Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	v 28b, Time	of 28c. In	njury at Vork? □ Yes 2 □ N	28d. Describe h			ury)
Division	To the Hospital or Attani within 24 hours after deati To the Funeral Director: completely filled in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injuding, etc	ury - At home, farm, s c. (Specify)	treet, factory, offic	ce	28f. Location (S City or Ton		Number or Ru	ral Route Number,
	To the Hospital or within 24 hours after To the Funeral Dircompletely filled in I	edicai	29a. Certifier (Check only one) Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifier (Check only one)	ician: To the best ler: On the basis of and manner sta	examination and/or	th occurred at the nvestigation, in m	e time, date and y opinion, deat	d place, and due to the ohoccurred at the time,	cause(s) a date and p	nd manner as place, and due	stated. to the cause(s)
)	To the within 2 To the complet	Me	29b. Signature and title of certifier	Suil	mis	29c. Lice	onse number	94	29d. Date	signed (Mont)	Day, Year)
	,		30. Name and address of person who co	1 /	eath (Item 23a) (Type	Print)	110//	Ave. Gai	the o	1	And softe
	Sta Registr		31. Date filed (Month, Day, Year) OCT 18	32. Registr	r's Signature	B A	books	/	1, 41.	ouf,	14.0017

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. # 9, per FH, G837, 11/3/04 TT State of Maryland / Department of Health and Mental Hygiene Amend item # Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 11,2004 **Physician** Edwin Nah 10:25 pM /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Hospital Montgomery Rockville
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreig Country) Liberia 6. Sex 11 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
12-07-1942 **Funeral** Months 154-04-3604 61 Director West Usuel Residence of Decedent death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or iteme 23a or 28a-f show the Medical Examiner must be notified at 1. Yes 2 □ No Director Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18861 Bent Willow Circle #841 20874 Liberia 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, GiveA Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: δ Specify: 3 ☐ Widowed 4 ☐ Divorced **Black** 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. importent: if item 27 is marked other then "na any injury or other treumatic event, the M-JIC 9058. College (1-4or 5+) Elementary/Secondary (0-12) Administrator Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alston S. Nah Tedueh Μ. Sekleh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Olive K. Nah - Wife 18861 Bent Willow Circle, #841 Germantown, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Souls Cem. 10/23/04 * 4 ☐ Donation 5 ☐ Other (Specify) Germantown, MD 22. Name and Address of Facility Taylor's Funeral Home 21. Signature of Funeral Service Licensee 1722 North Capitol St., NW Washington, DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between fmmediate Cause (Final disease or condition resulting in death) Onset and Death Priysician Liver Failure 4 days /Medical Due to (or as a consequence of): Examiner Gall Bladder Cancer 22 months Sequentially list conditions, if any, leading to immediate and the sequence of Due to (or as a consequence of). Examine ed by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Gastrointestinal Bleeding 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 2 No 1 ☐ Yes 2 XNo 1 ☐ Yes al or Attending Physician: T s after death. ii Director: After this certificat 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 27. Manner of Death 1 XNatural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide ro the Hospitai 1 date and place, and due to the cause(s) and manner as stated.
2 date and place, and due to the cause(s) and manner as stated.
2 date and place, and due to the cause(s) and manner as stated. 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 051714 Mul (Or October 12, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sekhon, Jatinder - 2401 Research Blvd., Suite 102 Rockville, Md. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State OCT 1 5 2004 Registrar

DHMH 17 Rev 1/2001

Amended #10e, nls, 10/18/04, Allegany Co.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygi

Certificate of Death

Reg. No. 00 4	34369
2. Date of Death	3. Time of Death

	1. Decede	nt's Nar	ne (First,	Middle,	Last)
Physician /Medical	RA	Y	JUN	IOR	
Examiner	4a. Facility	Name	(If not ins	stitution,	give s

П	Physic /Medi		RAY JUNIOR O'BRIEN			Month	1 Say Ye	14 8:30 A
	Exami		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Loca		4c. County of [1 0 0 0
ı			Sourced Heart Hosp	s, tal	Cumber	land	Alle	12005
Г	Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year If U	nder 24 Hrs. 8, Date of B		Birthplace (State or Foreign
	Director		578-46-4604 X□M 2□F	68 Yrs.	Months Days Ho	OCT. 2		EST VIRGINIA
	p .		Usual Residence of Decedent	10- 0': T				
	aryla shov	L		10c. City, Town or Loc				10d. Inside City Limits
	Ba-f	cto	111111111111111111111111111111111111111	FLINTS	TONE			1 □ Yes 2X No
	ith th	Director	10e. Street and Number NATIONAL		10f. Zip Code		10g. Citizen of Wha	t Country?
	23a		27511 N.E. NATINAL PIK		21530		U.S.A.	
	r de	Funeral	11. Marital Status 12. Was Decedent Ev Armed Forces?	er in U.S. 13. V	Vas Decedent of Hispan Yes, specify Cuban, Me	ic Origin? (Specify Yes or Nixican, Puerto Rican, etc.)	lo- 14. Race - A	American Indian, White, etc.
36	or i	by Fi	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 No		37	ecity:	Specify:	
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If itam 271s marked other than "natural", or itams 23a or 28a-f show or other traumatic svent, the Medical Examinations is conflicted.	d b	3 Widowed 4 Divorced Year or Dates:					WHITE
Ϋ́	"nat	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupation kind of work done during DO NOT use retired)	most of working	16b. Kind of Busine	ess/Industry
7	withir ane. than	m	Elementary/Secondary (0-12) College (1-4or 5+)				CONST	TRUCTION
7	filled wil Hygien othar th		17. Father's Name (First, Middle, Last)	CA	RPENTER	Mother's Name (First, Middl		ROCITON
ä	ntal l	Be	ROBERT E. O'BRIEN					
Ë	2 should be and Mental is marked c	To		405.44.75		ELLA MAE VA		
<u>8</u>	12 s h an 7 is r traur		19a. Informant's Name/Relationship (Type, Print)			umber or Rural Route Num		
	1 and Health am 27 ther tr		BARBARA O'BRIEN / WIFE 20a. Method of Disposition	2/511 20b. Place of Dispos	N.E. NATIO	NAL PIKE, FL	INTSTONE,	MD 21530
ō	Pages nent of B int: If its iry or of		1 Burial 2 □ Cremation 3 □ Removal from State	cemetery, crem	natory or other place)		20c. Location - City	or Iown, State
ltimore,	pernit. Pages 1 ar Department of Hea Important: If itam any injury or othe once.		`4 □Donation 5 □Other (Specify)	ABE CEME		10/18/2004	RIDGEL	EY, WV
Ba	pernit. I Depirtm Importa any nju		21. Signature of Funeral Service License	Űı	PCHURCHTFUN	ERAL HOME, P.	.A.	
-	402 e d		waxy of agreen	W 20	02 GREENE S'	TREET, CUMBER	RLAND, MD	21502
			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	e death. Do not ente	er the mode of dying, suc	h as cardiac or respiratory	arrest,	Approximate Interval Between
5	Physician		Immediate Cause (Final disease or condition	Sterry 1	- chroni	e obstructei	ve Du ma	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a continuous according to the continuous according	consequence of:	1,	d	isecole	, , , , , , ,
8	Examiner	١. ا	Sequentially list conditions b. Ziyht	upper	lobe p	neu monia		of deep
	p #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	const du nce of):	/			
	ocute nd trans	am	Cause (Disease or injury that initiated events	restert	evu			8 year
o	e exe ian a irial-		resulting in death) Last Due to (or as a c	consequence of):				-
68760	ate b nysic he bi	Ca	d					
39	death certificate be ехесиted e attending physician and nd for use as the burial-transit	ysician/Medical	IF FEMALE:					
Вох	th ce lendi	an/h	23b. Was decedent pregnant 23c. If yes, outcome of		Ectopic pregnancy		23d. Date of	delivery
O. E	Q 0 Q	SICI	1 Yes 2 No 4 Pregnant at tin		Other (specify)		Month	Day Year
<u>Т</u>	at the by th tache	-	9 ☐ Unknown					
	The law requires that to the has been signed by bage 2 should be detact	by Pt	Part II. Other significant conditions contributing to death but	not resulting in the une	derlying cause given in F	Part I. 23e. Did	tobacco use contribut	e to the cause of death?
Ö	w require been sig should b	ed				1 🔯	Yes 2□No 3□	Probably 4 Unknown
Vital Records,	s bee	Completed				24a. Was	s an 24b. Were	autopsy findings available
Ä	The lay	mc					ormed2 prior death	to completion of cause of
g	(0)	Ü	25. Was case referre medical		00.5	1 Tes	2 ☑ No 1 □ Y	/es 2□No
		0	examiner? 1 Yes 2 No Hospital: 1 Inpatient	2 ☐ ER/Outpatient	Oth -	Place of Death Check onl	100	
ō	<u>a</u> = <u>a</u>	\vdash	27. Mann of Death 28a. Date of Injury	28b. Time of	3L DOA 4L	Nursing Home 5 Res	how injury occurred	Specify)
0	or Attending Phater death. Diractor: After the in by the funeral	tlor	1 ✓ atural 5 ☐ Pending (Month, Day Y 2 ☐ Accident investigation	(ear) Injury	28c. Injury at Work? M 1 ☐ Yes			
S	ttendi death. ctor: A y the fu	fica	3 Suicide 6 Could not be 28e. Place of Injury	- At home, farm, stree			(Street and Number or	- Rural Route Number
Division of	after Dira	Certification:	4 Homicide determined building, etc. (Specify)	or, ractory, ornos		wn, State)	Tibrai Fioble Number,
	pita ours paral		29a. Certifier 12 Certifying Physician: To the best of r	ny knowledge, death	occurred at the time, det	e and place. and due to the		
	s Hospital 24 hours a a Funaral l letely filled	edical	(Check only 2 Medical Examiner: On the basis of example)	camination and/or inve	estigation, in my opinion,	death occurred at the time,	, date and place, and o	due to the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier		29c. License numb	Der	29d. Date signed (Mo	onth, Day, Year)
	11) Tel avece	. 1	DO 8	ミフフ	10-15-0	
	7		30. Name and address of person who completed cause of deal	th (Itam Con) (Time To		211	10-15	
	nas		PRUTIEIVELCHDIC 90		•	mborland	112 100	2
	Sta	te.	31. Date filed (Month, Day, Year) 32 Registrar's		1	1.426 1020	ma 2130	مسل ن
	Registr		OCT 1 8 2004	1 19	Sparke			

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiege

			For State Registrar	State of Ma	ryland / De C	partment of F e <i>rtificate of</i>	nealth and N Death	nental Hy	giene 004	34370	
ı	Pĥysicia	an	1. Decedent's Name (First, Middle, La		01-1			2. Date of De		3. Time of Death	
	/Medic	al .	Betty Lou Eller 4a. Facility Name (If not institution, give		Oblea	the Other Towns	or Location of Death		r 12, 2004		
	Examin	er	Holy Cross Hosp				Spring		Montgomery		
	Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs. last birthda	v) If Under 1 Year	If Under 24 Hrs.	8. Date of Birt		lirthplace (State or Foreign Country)	
	Director		5/9-48-2339	□M 2XF 69	Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da 11/12	/1934 No	. Carolina	
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location			<u></u>	10d. Inside City Limits	
	death with the Maryland ms 23a or 28a-f show	tor	VA Fairfax		Annand	ale				1 ☐ Yes 2 🔀 No	
	or 28s	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?	
	23a c	ral	4110 Mangalore	Drive #302		22003			USA		
	tems	Funeral	11. Marital Status	12. Was Decedent 8 Armed Forces?	er in U.S.	 Was Decedent of I If Yes, specify Cub 	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Race - Ar Black, W	nericen Indian, nite, etc.	
20	rs afta I', or I	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🖾 Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	lo	1 ☐ Yes 2 💢 No	Specify:		Specify: W	hite	
12-0030	be filed within 72 hours after death with the Marylar lat hygiene. d other than "natural", or Items 23a or 28a-f show event, It a Madical Examilier mast be notified at		15. Decedent's E	ducation	16a. De	cedent's Usual Occup	pation	do a	16b. Kind of Busines	ss/Industry	
N I	thin 7 e. an "n	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5	+) life	ve kind of work done . DO NOT use retire	d) d)	ang			
N	e filed within al Hygiene. I other than " vent, IL e Me		47 Feshada Nama (First Middle Last	1	C1	erk.	10 Mothada Nam	o (Eimt Middle	Automot Maiden Sumame)	ive	
yland	ntal H ed ot	Be	17. Father's Name (First, Middle, Last, Oscar John McKa					arian Jo			
Ž	2 should be f and Mental I Is marked of raumatic eve	은	19a. Informant's Name/Relationship (19b. Ma	ailing Address (Street			er, City or Town, State	, Zip Code)	
Mar	nd 2 salth ar 27 ls r trau		Larry D. Dixon	- son					nsville, M	•	
Je,	item item		20a. Method of Disposition	70	20b. Place of Dis	sposition (Name of rematory or other pla	ce)	Date	20c. Location - City	or Town, State	
Ē	Page ment cant ury or		1 ☐ Burial 2 🏹 Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specification)	y)	1	itan Crem	1	13/2004	Alexandr	ia, VA	
Baitimore,	parmit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury og other traumatic er ones.		21. Signatura Europal Service Lice	/		22. Name and Address Advent Fu	1 0	vices			
	45240		23a. Part 1. Enter the disease, or com shock, or heart failure. List only	blications that caused	the death. Do not o	7211 Lee	Highway	Falls Ch	nurch, VA	22046 Approximate	
	Dhusisian		immediate Cause (Final							Interval Between Onset and Death	
-	Physician /Medical		disease or condition resulting in death)	w	age cnron a consequence of):	ic obstru	ctive puli	monary o	11sease		
	Examiner		Sequentially list conditions	sepsis							
ŀ	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	à sunsequence of):						
	xecute and II-tran	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequence of):	·-					
68/60,	icate be executed physician and s the burial-transit			d							
_	tificat ng phy as th	Aedicai	15551415								
gox	leath certifii attending (I for use as	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 □Ectopic pregnanc	y		23d. Date of o	delivery Dav Year	
0.	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	1 Yes 2 No	4□Pregnant at 9□Unknown	time of death	5 ☐ Other (specify) _			THO ALL	Day	
1	that the	y Ph	Part II. Other significant conditions	contributing to death b	ut not resulting in the	underlying cause gr	ven in Part I.	23e. Did to	obacco use contribute	to the cause of death?	
Records,	w requires that been signed to should be deta	ed by						1 🔯 🗅	Yes 2□No 3□	Probably 4 Dunknown	
000	lawre as bed 2 sho	Completed						24a. Was	an 24b. Were	autopsy findings available o completion of cause of	
ř	The law	Com							rmed? death	? es 2□No	
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		Ott	26. Place of Deal				
	Phys r this ral dir	. To	1 ☐ Yes 2 💢 No 27. Manner of Death	28a. Date of Inju	ry 28b. Time	e of 28c. Inju	rv at		dence 6 Other (S)	pecify)	
on	nding th. : Afte e fune	ation	1 X Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Da	y Year) Injur	y Wo	rk?]Yes 2 □ No				
Division of	r Atter er dea rector by the	Certification:	3 Suicide 6 Could not be determined		ury - At home, farm,	street, factory, office		28f. Location (S City or Tox	Street and Number or wn, State)	Rural Route Number,	
ā	ital or irs afti ral Di lled in							-			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director,	Medical		nysician: To the best miner: On the basis of and manner sta	examination and/or						
	To the Within To the	Me	29b. Signature and title of certifier			29c. Licen			29d. Date signed (Mo	nth, Day, Year)	
)	12		1 013	MD.			0.52580	5	10/12	104	
	17		30. Name and address of person who	completed cause of d	eath (Item 23a) (Typ	De. Print) 14 (1055 Apart	Hospi	ital.			
	Sta	te	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	17 (1033	1102/1	,,,,			
9	Regist		OCT 14 20	104 April	va B	Spark	A STATE OF THE PARTY OF THE PAR				

State of Maryland / Department of Health and Mental Hygienes 34371 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** october MARY BLANCHE OVERBAY 16/2004 /Medical 4a Facility Name (If not institution, give street and number) If Under 1 Year | If Under 24 Hg. 4b. Gity, Town, or Location of Deeth 4c. County of Death Examiner 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M M F Yrs 90 224-18-5615 Virginia Director 5/1914 Usuel Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Rems 23a or 28a-f showing the must be notified at 1 Yes 2 No Director MD. Harford Forest Hill 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1215 W. Jarrettsville Road 21050 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Merried ò 21215-0020 1 ☐ Yes 2 No Specify: Be Completed by 3 Widowed 4 Divorced Year or Dates: White 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 0 Seamtress Clothing Pages 1 and 2 should be filed nent of Health and Mental Hygi ant: If Itam 27 Is marked other Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Leonard Henry Ollie Magadelene Kegley 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 21050 19a. Informant's Name/Relationship (Type, Print) Carol D. Fowler/Daughter 1215 Jarrettsville Rd. Forest Hill, Md. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 10720 ò 4 ☐ Donation 5 ☐ Other (Specify) 2004 Air Mem. Gardens Bel Air, Maryland 21. Signature of Funeral Septice Licent 22. Name and Address of Fecility E.G. Kurtz & Son Funeral Home. P.A. Jarrettsville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final diseese or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Medical Certification: To Be Completed by Physician/Medical Examiner Blanche The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of) Due to (or as e consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 XNo 3 Probably 4 Unknown within 24 hours efter death.

To the Funeral Diractor: After this certificate has been signed completely filled in by the funeral director, page 2 should be del 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? ZUNTYU 1 ☐ Yes 2 ☐ No Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: Nursing Home 5 - Residence 6 - Other (Specify) 1 ☐ Yes 2 ☑ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 🗆 No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) 31. Dete filled (Month, Day, Year) State 2004 OCT 2 0 Registrar

34372 State of Maryland / Department of Health and Mental Hygiene [] [] [] Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 7:45 A. October 19,2004 Albert Luther Palmer Jr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner 924 Main Ave. Washington Hagerstown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1**X** M 2□ F Aug.10,1923 219-14-9250 81 Director Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-fahow ith and Mental Hygiene. 27 Is marked other than "natural", or Itams 23e or 28e-f ahov treumatic event, the Mudical Examinar must be notified at 1 XYes 2 No Director Washington Hagerstown 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 924 Main Ave. 21740 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item eny injury or other treumatic event, the Mudical Exercises 2008. 1♥ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specity: White 41 - 46Š 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Auto Body Technician Auto Co. 6 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Albert Luther Palmer Sr. Ethel Gigeous 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 924 Main Ave. Hagerstown Md. 21740 Lula Mae Palmer (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Oct.20,04 Smithsburg Crematory Smithsburg, Md. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. Moluly J.L. Davis Funeral Home Smithsburg, Md. 234 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the disease in the cardiac or respiratory arrest, and the cardiac or respiratory arrest or respiratory Approximate Interval Between Onset and Death Atheroselerotic Immediate Cause (Final Cardievascu Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to or as a consequence of): Exan iner The law requires that the death certificate be executed burial-trag that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) signed by the at d be detached fo 1 Yes 2 No o 9 Unknown م 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 1 Yes 2 No 3 Probably 4 donknown should b 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s 1 ☐ Yes 2 - No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examine? Be 26. Place of Death (Check only one) funeral director Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 res 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending after death.
I Director: Aff
d in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certi-00 4408 51 of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

Antietam St. Hagerstown, Md. 21740

M.D.

Thomas Gilbert

31. Date filed (Me

251 Ε.

32. Registrar's Signature

		,	1 - For State Registrar	State of Mary	and / Depa	artment o	of Health and of Death	Mental Hyg	giene 004	34373
	Physici	an	Decedent's Name (First, Middle, La MET NEN					2. Date of Dea Month		3. Time of Death
	/Medi		MELVIN	PEOPLES		1		October	11,2004	8:35am M
	Examir	er	4a. Facility Name (If not institution, giv			4b. City, Tov	vn, or Location of Dea	ath	4c. County of Dea	ath
	Funeral Director				yrs. last birthday) 2 Yrs.	If Under 1 Y	over ear If Under 24 Hr ays Hours Mir		Prince Ge	orges rthplace (State or Foreign auntry) DC
	and **		Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or Lo	ocation				10d. Inside City Limits
	Maryll faho	ō	MD Prince G		andover					1 Tyes 2 No
	1 the	Director	10e. Street and Number			10f. Zip Coo	de	1	Og. Citizen of What C	ountry?
	th with		4133 Warren Ave.			2078	5		USA	
920	72 hours after death with the Maryland netural', or Herns 23e or 28e-f show dical Exercitive Frank be redified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent If Yes, specify (1 ☐ Yes 2 ☐	of Hispanic Origin? (Cuban, Mexican, Pue No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Wh Specify: B1	ite, etc.
2-0	n 72 hours "natural", Luical Ext	etec	15. Decedent's Ed (Specify only highest gra		16a. Dece	dent's Usual Oc	cupation one during most of we	orkina	16b. Kind of Business	Industry
121	ed within /giene. er than *	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use re Weld	itired)	J. T. T. T. T. T. T. T. T. T. T. T. T. T.	D	
2	77		17. Father's Name (First, Middle, Last)			werd		ame (First, Middle, i	Privat	е
Maryland 21215-0036	s 1 and 2 should be filed f Health and Mental Hyg item 27 is marked othe other traumatic event,	To Be	Ernest Peoples Si	r.	19h Mailir	ng Address (St	Pauline	e Rose	, City or Town, State,	7.0.0
Ma	nd 2 sulth an 27 is rireu		Annie Arrington			Owen P1		nington,		ZIP COGB)
re,	of Heal		20a. Method of Disposition	20	b. Place of Dispo cemetery, crer	sition (Nama o	,		20c. Location - City or	Town, State
E	Pages nent of I unt: If its ury or o		1 🖾 Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify		rmony M	em. Pk.	Oct	.16,2004	Landover,	MD
Baltimore,	permit. Pages Department of Important: If i eny injury or once.		21. Signature of Funeral Service Licer	Lento					Jenkins In	
	Physician physician and physician and state physician and state physician and state physician sit the principle.	I Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, france Labert Underlying Cause (Disease or injury that intiated events resulting in death) Last		sequence of):				ent Dis	Interval Between Onset and Death
P.O. Box 68760,	I the death certif by the attending ached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	d	etal death 3 C	Ectopic pregna)		23d. Date of de Month	livery Day Year
	w requires that been signed should be det	by	Part II. Other significant conditions of	ontributing to death but not	resulting in the ur	iderlying cause	given in Part I.	1	acco use contribute to s 2 □ No 3 □ Pi	the cause of death?
al Records,	: The law re cate has be	Completed						24a. Was ar autops perform 1 Yes 2	prior to death?	utopsy findings available completion of cause of
of Vital	Physician: r this certilica ral director, p	Be	25. Was case referred to medical examine?	Hospital:	_		Other	ath (Check only one		
on of	Attending Physic death. sctor: After this by the funeral di	tion: To	1	28a. Date of Injury (Month, Day Year	ER/Outpatien 28b. Time of Injury	28c. lr	4 Nursing Finjury at Work?	10me 5 Reside 28d. Describe ho	nce 6 Other (Spe w injury occurred	cify)
Division	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certilicate ha completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp.	t home, farm, streecify)	et, factory, office	ce	28f. Location (Str City or Town	eet and Number or Ru State)	ıral Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my niner: On the basis of exam and manner stated.	knowledge, death iination and/or inv	occurred at the estigation, in m	e time, date and place by opinion, death occu	a, and due to the ca urred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and title of certifier	111 -			ense number		d. Date signed (Monti	
,	1		Sahader,	Bhoty 3	20	H	005592	0	c706 2 14	9 2006
K	(2)		30. Name and address of person who of SALVALLY Syl	rsten 300	or Hosy	Print)	Drive	Cherry	15125 / 14	4nd
	Sta Registr	re.	31. Date filed (Month, Day, Year) OCT 1 8 2004	2. Registrar's Si	gnature			"/		

amend 24-29 per Dr. galanse 10/28/04Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 34374 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Day **Physician** Year Heavenly Angel Marie Price Ju1¥ 2004 02:47 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital Leonardtown St. Mary's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) | 24 July 4, 200 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 ☐ M 2 🖾 F Yrs. none July 4, 2004 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at MD St. Mary's Callaway 1 ☐ Yes 2 ☑ No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19945 Piney Point Road Items 23a 20620 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced black Year or Dates: "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) none College (1-4or 5+) Elementary/Secondary (0-12) filed within Hygiene. none none permit. Pages 1 and 2 should be filed Department of Health and Mental Hygin Important: If tiem 27 is marked other any injury or other traumatic event. It unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Laketa Price 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) St. Mary's Hospital 25500 Lookout Road Leonardtown, MD 20650 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🛣 Other (Specify) in state 21. Signature of Funeral Service Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street win Baltimore, MD 21201 23a. Pair 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Xtreme **Physician** rematerity 20 monutes disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Ple Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons Examiner and physician ar s the burial-t Due to (or as a consequence of) 68760 Physician/Medical SE IF FFMALE P.O. Box nse (23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Day Year 4□Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 EN/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred

ANGEL MARIE HEAVENLY

Division of Vital Records. the funeral director, this within 24 hours after death.
To the Funeral Director: After this completely filled in hours.

Medical State Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier whane Ina

5 Pending

investigation 6 Could not be determined

29c. License number

1 ☐ Yes 2 ☐ No

D0061186

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BIRHANE OLJIRA M.D. P.O.BOX 527 LEONARDTOWN, MD. 20650

31. Date filed (Month, Day, Year)

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

OCT 2 8 2004

32. Registra 's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

		l	1 - For State Registrar	State of Man		artment of Hetificate of L			iene ••• ••• • • • • • • • • • • • • • • •	01075
	Physicia		1. Decedent's Name (First, Middle, Last)	FAY	PAULSO			2. Date of Dear	th 2004	
-	/Medic Examin		4a. Facility Name (If not institution, give s Renaissance Cardens at	street and number)	llam	4b. City, Town, or Silver	Location of Death	00,002,	4c. County of D	eath
	Funeral Director		5. Social Security Number 6. Sex		n yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	8. Date of Birth (Month, Day, March5,	Birth Day, Year) 5,1920 Prince George's 9. Birthplace (State or Foreign Country) Minnesota		
	Maryland f ehow	or	Usual Residence of Decedent 10a. State 10b. County Maryland Prince G		oc. City, Town or Lo Silver S					10d. Inside City Limits 1 ☐ Yes 2X No
	h with the I 3e or 28e- at be notif	al Director	10e. Street and Number 3148 Gracefield Ro		511101 5	10f. Zip Code 2090	04	1	Og. Citizen of What	
036	d within 72 hours after death with the Maryland jiene than "natural", or Itema 23e or 28e-f ehow tra Madical Examinar must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 【X Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? \$\times Yes 2 \subseteq No If Yes, Give Year or Dates: \times \times	li li	Vas Decedent of His i Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - A Black, W Specify:	merican Indian, hite, etc. White
21215-0036	within ene. than "	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation	16a. Deced (Give life. L	lent's Usual Occupa kind of work done di DO NOT use retired) of Libera	uring most of work	ing	Penn Sta Universi	ss/Industry te
힏	e file al Hyg I othe vent,	To Be C	17. Father's Name (First, Middle, Last) Adolph		ılson		18. Mother's Nam Ida Mae		Maiden Sumame)	
	es 1 and 2 should b of Health and Ments f item 27 le marked r other traumatic e		19a. Informant's Name/Relationship (Type Richard S. Paulson	n -son	902 F	alls Brid		Great Fa	City or Town, State	22066
altimore,	t. Pag rtment rtent: I		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Metropoli	atory or other place tan Crema	atory 10/	12/2004	Alexandr	ia, Virginia
Bal	Departing Sany in Sany		21. Signature of Funeral Service License Oracle 23a. Part1. Enter the disease, or complishock, or heart failure. List only or	Bugwar	at 120	nald V. E 00 Powder	or Facility Sorgwardt MILL RO	Funeral ad Belts	Home, P.	A. aryland 20705
	Physician /Medical care percented and physician and the prival-transit the prival-transit.	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ng tastas is	Interval Between Onset and Death Mouth					
.O. Box 6	that the death certifi ed by the attending detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Mo 9 □ Unknown	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of o	lelivery Day Year
<u>α</u>	sign d be	by	Part II. Other significant conditions con	atributing to death but n	ot resulting in the un	derlying cause giver	n in Part I.	23e. Did tob		to the cause of death? Probably 4 □Unknown
Vital Records,	(0 ==	Completed						24a. Was an autopsy perform	/ prior to	
of	Attending Physician: Thr death. ector: After this certificate by the funeral director, pag	atlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 H 27. Manner of Peath 1 Matural 5 Pending investigation	ospital: 1 Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatient 28b. Time of Injury	3□ DOA Other 28c. Injury : Work?	at Nursing Ho		nce 6 Other (Sp	pecify)
Division	in Die	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (5	- At home, farm, stre Specify)	et, factory, office		28f. Location (Str. City or Town,		Rural Route Number,
	the Hoepital or in 24 hours afte the Funeral Dir ipletely filled in	edical	29a. Certifier 1 Pertifying Phys (Check only 2 Medical Examinate)	sician: To the best of m ner: On the basis of exa and manner stated	amination and/or inv	occurred at the time estigation, in my opi	e, date and place, nion, death occurr	and due to the ca ed at the time, da	use(s) and manner te and place, and di	as stated. ue to the cause(s)
	To the To the Complet	2	, , , , , , , , , , , , , , , , , , , ,	umana,	MD		1524		od. Date signed (Moi October 1	
_			30. Name and address of person who co LOVEEN J PUTHUMA	NA 3110 6	ARACEFIE	ELD ROAL	SILVE	RSPRIN	16 MD 2	10904
	Sta Registra		31. Date filed (Month, Day, Year) OCT 14 200	32. Registrar's	Signature	Sparks	/		,	

			1 - For State Registrar	State of Ma		d / Depa		t of H	lealth a		-	giene	004	34376
	Physici	an	1. Decedent's Name (First, Middle, Last,								2. Date of De	ath Day	Year	3. Time of Death
	/Medi			NAOMI	M .	PRICE						-	004	12:15 PM
	Examir	ner	4a. Facility Name (If not institution, give						Location of				County of Dea	
			634 LITTLESTOW		. //				INST				CARRO	
	Funeral Director		5. Social Security Number 6. Sec. 120 – 16 – 1466	x 7.Age]M 2∏gF	78	ast birthday) Yrs.	If Under Months	Days	If Under : Hours	Min.	8. Date of Birt (Month, Da	y, Year)	9. Bi	rthplace (State or Foreign ountry)
			Usual Residence of Decedent		70						9/5/1	926	MA.	RYLAND
	ylan how		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	e Ma	ctor	MD CARROLL		WE	STMIN	STER							1 X Yes 2 □ No
	ith th or 28	Funeral Director	10e. Street and Number				10f. Zip	Code				10g. Citiz	en of What C	ountry?
	ath w	ra	634 LITTLESTOW			,		115				USA		
	er de Items	nue	11. Marital Status	12. Was Decedent E Armed Forces?		S. 13. \	Vas Deced f Yes, spec	ent of Hi ify Cuba	spanic Orig n, Mexican	jin? (Spe , Puerto l	cify Yes or No- Rican, etc.)	. 14	 Race - Am Black, Whi 	
36	irs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕅 N If Yes, Give Year or Dates:	0		I□Yes 2	2X No	Specify:			5	Specify.WH	ГТЕ
9	i within 72 hours after death with the Maryland liene. r then "natural", or Items 23a or 28a-f show The Medical Examiner must be rooffied at	ted	15. Decedent's Edu	cation		16a. Deced	lent's Usua	I Occupa	ation				d of Business	
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7		Completed	10		<u></u>	PF	RESSE	ER				SEWI	ING F	ACTORY
p	m = 0 %	Be (17. Father's Name (First, Middle, Last)								(First, Middle,	Maiden S	umame)	
yla		으		J.C. SCI	HROY					LLI				
Maryland 21215-0036	d 2 should th and Mer 7 is marke traumatic		19a. Informant's Name/Relationship (Ty		מזא א	19b. Mailin	g Address	(Street a	and Numbe	r or Rura.	Route Numbe	r, City or	Town, State,	Zip Code)21157
	1 an 1eal 3m 2 ther	1	RICHARD L. PRIC	LE -HUSBA		ace of Dispo			TOMM		KE, WE			·
Baltimore,	0 0		1 XBurial 2 ☐ Cremation 3 ☐ F	Removal from State	CB	emetery, cren	natory or of	her placi					ation - City or	
둂	permit. Pag Department Important: t any injury o		'4 □ Donation 5 □ Other (Specify) 21. Sign 1 □ □ Service License		EVER									RG, MD.
Ba	permit. Departm Importa any inju		SI SIGNICO EICONS								TCHER			номе MD. 21157
	-		23a. Part1. Enter the disease, or compli	ications that caused	the death.								IER,	Approximate
	Dhysisian		Immediate Cause (Final	ne cause on each line	θ.			_	,		,			Interval Between
}	Physician /Medical		disease or condition resulting in death)	Due to (or as a			NCE	<						6 montes
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		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequ	ence of):								
	cuted nd transi	Examiner	triat initiated events	· ·										
ó,	be executed ician and burial-transit	m	resulting in death) Last	Due to (or as a	conseque	ence of):								
8760,	icate be executed physician and s the burial-transit	dical		d										
9 ×	law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	Physician/Med	IF FEMALE:	20 16										
Вох	attenc for us	ian	in the past 12 months?	3c. If yes, outcome o	2 Fetal	death 3 🗆	Ectopic pre					23	 d. Date of dea Month 	livery Day Year
P.O.	at the de by the a tached i	ysic	1 □ Yes 2 ☑ No 9 □ Unknown	4☐ Pregnant at t 9☐ Unknown	ime or dea	atn 5_	Other (spe	эспу)						,
۳.	res that i		Part II. Other significant conditions con	ntributing to death but	t not resul	lting in the ur	derlying ca	use give	n in Part I.		23e. Did to	bacco use	contribute to	the cause of death?
ds	puires sign	d by									1 2 Y	es 2 🗆	No 3∏Pr	obably 4 Unknown
Records,	w requir	lete									24a. Was a	ın.	24h Were a	utopsy findings available
ď	The lavate has page 2	Completed									autop: perfor	sy med?	prior to death?	completion of cause of
	ician:] certifical ector, p	a	25. Was case referred to medical		-				26 Place	of Death	1 ☐ Yes (Check only or	2 2 No	1 🗆 Yes	22 No
\geq	99 00 =	To B	examiner? 1 \(\text{Yes} 2 \(\text{No} \)	lospital:	t 2 🗆 E	R/Outpatient	3 DO	Othe			ne 5 ½ Resid		Other (Spe	cify)
	ding Phy h. After this funeral c		27. Man of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year)	28b. Time of Injury	28	c. Injury Work	at		8d. Describe h			
<u>0</u>	Attsnding r death. sctor: After y the fune	atlc	2 Accident investigation	,,		,,	М		es 2□N	lo				
Division		Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	ry - At hon (Specify)	me, farm, stre	et, factory,	office		2	8f. Location (S. City or Town		Vumber or Ru	ıral Route Number,
Ω	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in						_			<u> </u>				
	o the Hospital thin 24 hours of the Funeral I mpletely filled	edical	Check only 2 Medical Exemi	sicien: To the best of ner: On the basis of e	examinatio	rledge, death on and/or inv	occurred a estigation,	it the time	e, date and inion, death	place, a	nd due to the c d at the time, d	ause(s) ar ate and pi	nd manner as lace, and due	stated. to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner state	ed.			License					signed (Monti	
	To To			aldetu				26		>			-/3	
(M		30. Name and address of person who co	moleted cause of de-	ath (Itam)	230) (Time 1						/	1-	/
,	N.N		NORMAN GOLDSTEI		218		,	נעטין	нето	umc	места	T NI (** 0	י מקד	4D 24457
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar	r's Signatu	1te			111516	штр	, WESTM	TN2,	LEK.	4D.21157
	Registr	ar	OCT 13 2	2004	w	15 1	pode							

State of Maryland / Department of Health and Mental Hygiege Reg. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 10 2004 Month **Physician** October Mary N. Peters 1:45 % /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 □ M 2√□ F Director 219-16-1180 80 1924 Maryland Usual Residence of Decedent with the Maryland in than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director TXT Yes 2 No Marvland Anne Arundel Lothian 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 20711 5059 Solomons island Road USA death Funeral 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. hours after 1 ☐ Yes 2 🔀 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Black þ Specify: 3€Widowed 4 □ Divorced If Yes, Give Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled will Department of Health and Mental Hyglent Important: If Item 27 is marked other that any injury or other traumatic event, Italy Once. 12th None 2 yrs. Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Herman Gray 2 Irene McGruder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Peters (Daughter) 5049 Solomons island Rd. Lothian, Md. 20711 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Zion UM Church 10/15/04 * 4 ☐ Donation 5 ☐ Other (Specify) Lothian, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Wm. Reese & Sons Mortuary 821 West St. Annapolis, M Seese MOOY83 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician aus /Medical Due to (Mas a consequence of): **Examiner** 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to burial-transit The law requires that the death certificate be executed Kena that initiated events resulting in death) Last and Due to (or as a consequence of) the attending physician Box 68760 Physician/Medical the IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ö in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has certificate 2 No 1 Yes the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one. Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner Joeath 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; After 5 Pending investigation 1 Matural Injury death. 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 6 ☐ Could not be 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined after 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 #53041 104 Parkway, Anup. Cs, MD 21401 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stan Z 2201 Mederal Muschof 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 3 Registrar

Physicia /Medica Examine	3
Funeral	

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		For State Registrar		State of Maryle		rtificate of L			Reg. No.	34370				
Physici	an	1. Decedent's Name)oooin			2. Date of De. Month	Day 70 Ye	3. Time of Death				
/Medic		Mary 4a. Facility Name (If I	Anr not institution, give str		assin	4b. City, Town, or	Location of Death		4c. County of D	7 1.00				
Examilia	ei	SACre	d HEAR	+ Hospit	AL	Cumh	erland	1	ALLE	SANV				
Funeral		5. Social Security Nu	1 1 1	4 20 E	rs. last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da May 30	h 9.	Birthplace (State or Foreign				
Director		292-46-45 Usual Residence of D	009	" ^{2X'}	115.			IMay 30	, 1947	Оп				
yland how		10a. State	10b. County	10c.	City, Town or L					10d. Inside City Limits				
Ba-f s	ctor	VA	Fairfax		Resto	on				Y⊖S 2 No				
with the	Dire	10e. Street and Num		Dd		10f. Zip Code	20191		10g. Citizen of Wha	t Country?				
Trs 23	eral	10993 TTI	rush Ridge	. Was Decedent Ever in	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba		ecity Yes or No		American Indian,				
after or Ita	by Funeral Director	1 Never Marrie		Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		1 ☐ Yes 2 No	n, Mexican, Puerto Specify:	Rican, etc.)		Vhite, etc.				
hours ural',	d by	3 Widowed 4		Year or Dates:	160 Dans				Specify: W					
in 72 n "nal	plete	(Specif	15. Decedent's Educa y only highest grade	completed)	(Give	edent's Usual Occupa e kind of work done o DO NOT use retired	during most of work	ring	16b. Kind of Busin	ess/industry				
giene giene er tha	Completed	Elementary/Secon	2	College (1-4or 5+)	Graph	ic Designe								
be file ital Hy id oth event	Be	17. Father's Name (F						e (First, Middle, ennett F	Maiden Sumame)					
2 should be filed withing and Mental Hygiene. Is marked other than aumatic event, the Manatic event, the Man	ို	Robert	ZEEK me/Relationship (Type	n. Print)	19b. Mail	ing Address (Street a				te Zin Code)				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itame 23s or 28s-f show any figury or other traumatic event, the Medical Exam har must be notified at ances.		Thomas		Husband		93 Thrush				VA 22091				
permit. Pages 1 and. Department of Health Important: If item 27 any injury or other tr once.		20a. Method of Dispo	osition Cremation 3 Rem	naval from State	cemetery, cre	osition (Name of matory or other place	e)	Date	20c. Location - City					
Pages tment of I tant: If its jury or o		° 4 ☐ Donation	5 ☐ Other (Specify)	Sc	· · · · · · · · · · · · · · · · · · ·	ıneral Home,			Cresapto	wn MD				
permit. Departn Imports any inju		21. Signature of Fun	eral Service Licensee	Same	100	2. Name and Addres Scarpelli								
		23a, Part1. Enter the	disease, or complication	ations that caused the de	eath. Do not en				land, MD 21:	Approximate				
Physician		Immediate Cause (F	failure. List only one inal	ANOXIC	ENIC	FPHAIN	PATHU			Interval Between Onset and Death 12 How21				
/Medical		disease or condition resulting in death)	a.	Due to (or as a cons	equence of):	EPHALO	HAIR			12110WZ				
Examiner	<u>.</u>	Sequentially list con-	ditions, b.			4RREST				12 HOURS				
ted nsit	Examiner	if any, leading to imr cause. Enter Under Cause (Disease or ir	nediate lying njury	A CANTE	_	ONARY	-1100	ROM		12 Hours				
tificate be executed g physician and as the burial-transit	Exai	that initiated events resulting in death) La	ast C.	Due to (or as a cons	equence of):	or write y	59111	210101		1 10 000				
ate be nysicia he bur	Medicai		d.											
entifica ling ph		IF FEMALE:	22											
eath cer attendir for use	Physician/	23b. Was decedent in the past 12 n	pregnant ponths?	the state of t	etal death 3	☐Ectopic pregnancy ☐ Other (specify)			23d. Date of Month	delivery Day Year				
res that the de signed by the a i be detached f	hysi	1 ☐ Yes 2 🔀 9 ☐ Unknown	140	9□ Unknown										
es tha gned be det	by P	Part II. Other signific	cant conditions contr	ibuting to death but not i	esulting in the	underlying cause give	en in Part I.		_	e to the cause of death?				
w requir been si should								101	′es 2□No 3□	Probably 4 Onknown				
e law has b	Completed							24a. Was autop		e autopsy findings available to completion of cause of h?				
in: The lificate ha	e Co	25. Was case referre	ed to medical				26. Place of Deat	1 Yes	2000 10					
Physician: this certific al director,	0	examiner?	Но	spital:	☐ ER/Outpatie	nt 3 DOA Othe	20		lence 6 Other (5	Specify)				
ding Ph h. After th funeral	on: T	27. Manner of Death	5 Pending	28a. Date of Injury (Month, Day Year,	28b. Time of Injury	of 28c. Injury Work	at	28d. Describe h	now injury occurred					
r Attendi er death. ractor: A by the fu	cati	2 Accident	investigation 6 Could not be	200 Blood of Initial A	hama farm at		Yes 2 □ No	28f Location /6	Street and Mumber o	r Dumi Pouto Alumbor				
after of Dirac	Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)												
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Diractor: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical C			cien: To the best of my ker: On the basis of exam and manner stated.										
To the within To the	Me	29b. Signature and t	itle of certifier	$\langle \rangle$		29c. License		1	29d. Date signed (M					
12		· W	Man	lam	mo	D2	5406		SCTOBER	12, 2004 land Md. 21503				
hee				pleted cause of death (I	tem 23a) (Type	. Print)	0 -		0 /	1 /201				
1100		WILLIAM	LAMM TO	IN MWH	S HOS	PITALIS	TPRO	GKAM	Lumber	land Md. 21503				

State Registrar

31. Date filed (Month, Day, Year) OCT 1 4 2004

32. Registrar's Signature

			Registrar				Ce	rtificate	of D	eath		Reg. N	lo.		
	Physici /Medio		1. Decedent's Nam John	n Henr	y Louis		iles				2. Date of D Month		2004		M M
	Examir	ier	4a. Facility Name (- A	ive street and number,			4b. City, Tov		ocation of Dear	th		c. County of E		
	Funeval		5. Social Security 1			DS P.I. T	H L ast birthday)	If Under 1 Y		f Under 24 Hrs	8. Date of B			Rithhlace (State or F	omian
	Funeral Director		222-24- Usual Residence of	-8261	1 x M 2 □ F		4 Yrs.			Hours Min.		ay, Yea		Birthplace (State or Fo Country) Bryland	Jieign
	ylanc		10a. State	10b. County		10c. City	, Town or Lo							10d. Inside City L	imits
	e Ma	ctor	MD	Dorche	ster		Ea	ist Ne	w M	arket				1 Tes 2	₹No
	or 28	Director	10e. Street and Nu					10f. Zip Co	de			10g. C	itizen of What	Country?	
	s 23a	ra		ffice B					216					States	
	Itam Itam	Funeral	11. Marital Status	ried 2 Married	12. Was Decedent Armed Forces 1 Yes 2	?	5. 13.	Was Decedent f Yes, specify	of Hisp Cuban, I	anic Origin? (S Mexican, Puer	Specify Yes or N to Rican, etc.)	0-		American Indian, Vhite, etc.	
920	urs af	þ	3 Widowed		If Yes, Give Year or Dates:	,10		1 ☐ Yes 2🌇	No 3	Specify:			Specify:	B1ack	
21215-0036	filed within 72 hours after death with the Maryland Hygiene ythar than "natural", or Itams 23a or 28a-f show ant, the Medical Examiner must be notified at	Completed	(Sne	15. Decedent's cify only highest g			16a. Dece	dent's Usual O	ccupatio	on	diaa	16b.	Kind of Busine	ess/Industry	
2	han "	mple	Elementary/Sec		College (1-4or	5+)		kind of work d DO NOT use re Oorer	etired)	ng most or wo	rking	C a.	. M.11	Factori	
7	lled w Hygiei thar ti		1.0 17. Father's Name	(First Middle I as	etl		Lat	orer	10	A Mothada Na	me (First, Middle			ractori	es
and	d be f antal h) Be	Ernest								G. Co1		,		
Maryland	shoulind Me mark	2	19a. Informant's N				19b. Mailir	ng Address (St			ural Route Numi			re. Zin Code)	
	alth a 27 is		Ella Ma	e Walk	er/Daught	er								'L 34205	
ore,	of Her		20a. Method of Dis	position	☐Removal from State	20b. Pla	ace of Dispo	sition (Name o	of nlace)		Date	20c. l	Location - City	or Town, State	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.		° 4 ☐ Donation	5 Other (Spec	cify)	Jo	hns C	emete	ry					Marylan	
Bai	Depar Impo		21. Signature of F	uneral Service Lic	o M. C	oal	21	Name and A	Mai:	n St.	rampton Feder	Fi	neral	Home P. MD 2163	A. 2
	*		23a. Part1. Enter shock, or he	the disease, or co	mplications that cause ly one cause on each I	d the death.								Approximate Interval Betwee	
	Pnysician i		Immediate Cause disease or condition	(Final	META	457	4720	, C	AX	REST	2			Onset and Dear	
	/Medical Examiner		resulting in death)		Due to (or as	a consequ	ence of):								
	LAGIIIIIEI	_	Sequentially list co	onditions,	b										
	ted	ulue	if any, leading to in cause. Enter Und Cause (Disease or	erlying	Due to (or as	a consequi	ence of):								
	al-trar	Examiner	that initiated event resulting in death)	s	c. Due to (or as	a conseque	ence of):							1	
ox 68760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit				d.										
9	rtificat ng phy as th	n/Medical	IF PENANT					_							
õ	th cer tendir or use		IF FEMALE: 23b. Was deceder		23c. If yes, outcome 1☐Live birth	of pregnan	cy death 3	Ectopic pregn	ancy				23d. Date of		
O. B	ie dea the at hed fo	/slcl	in the past 12 1 ☐ Yes 2: 9 ☐ Unknowr	□No	4□Pregnant a 9□Unknown		ath 5□	Other (specif)	n				Month	Day Year	
P. 0.	ires that the death signed by the atte I be detached for	by Physicia		-	contributing to death b	out not resul	ting in the u	nderiving cause	a diven i	n Part I	23e Did	tobacco	use contribute	e to the cause of death	72
ds,	uires signe d be								giveiri					Probably 4 Unkr	
Records,	w requir been si should I	lete									24a. Was	an	24h Word	autopsy findings avai	lablo
Re	The tay e has age 2	Completed									auto perfe	psy ormed?	prior	to completion of cause 1?	of
ā	ician: Th certificate ector, pag	0	25. Was case refe	rred to medical					26	S. Place of Dea	1 ☐ Yes	-	0 1 LY	'es 2□No	
>	Physici this ce al direc	To B	examiner? 1 \(\text{Yes} \) 2 \(No	Hospital:	ent 2 E	R/Outpatien	t 3 DOA	Other		lome 5 🗆 Res		6 ☐Other (S	pecify)	
0	ding Pl h. After ti funera		27. Manner of Dea 1 ★Natural	th 5 🗌 Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	28c. I	njury at Work?		28d. Describe	how inju	ry occurred		
<u>s</u>	Attending ar death. actor: After by the fune	cat	2 ☐ Accident 3 ☐ Suicide	investigati	bo					2 □ No					
Division of Vital	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	4 Homicide	determine		ury - At hon c. <i>(Specify)</i>	ne, farm, str	eet, factory, off	ice		28f. Location (Street a wn, Stat	nd Number or 'e)	Rural Route Number,	
	To tha Hospital or within 24 hours afte To tha Funaral Dir. completely filled in		29a. Certifier	1 Certifying F	hysician: To the best	of my know	ledge, death	occurred at th	e time.	date and place	and due to the	cause/s	s) and manner	as stated	
	To tha Hospital within 24 hours To tha Funaral completely filled	edical	(Check only one)	E Medical Exa	aminer: On the basis o	t examinatio	on and/or inv	estigation, in n	ny opinio	on, death occu	irred at the time,	date an	d place, and c	lue to the cause(s)	
	To tha within 2 To tha comple	×	29b. Signature and	title of certifier			1.7	29c. Lic	ense nu	ımber		29d. Da	ate signed (Mo	onth, Day, Year)	
			• /	NU	1		in	1 0	26	040		10	11410	3P	
			30. Name and add	-	completed cruse of c	leath (Item :	23а) (Туре,	Print)	2 01	ارتری		. 1	.1	Ld. 21613	
			31. Date filed (Mor	oth Day Year)	1	ar's Signatu	100 D	ramble	2 51	· suct	e A, Ca	mb	nage, k	1013	
	Sta Registr			OCT 2 2	2004	ar o oigitatt									
DH	MH 17 Rev 1/20		2.200	00166	2004		J 16	ments.							-11
						C	RIGINA	L							

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Vear **Physician** Quinn 10, 6:37 p October | 2004 Jacoba /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring Holy Cross Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 ☐ M 2 🖼 F Yrs. Director 86 May 18, 1918 **Netherlands** 579 40 7742 Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23s or 28s-f show the Modical Ers., it ar must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Wheaton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20902 USA Funeral 11604 Georgia Avenue 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. hours after 1 ☐ Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White à If Yes, Give Year or Dates: 3₺ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 72 filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Religious Minister $5\pm$ Counselor other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: if Item 27 is marked other any injury.or other treumests 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Iolanth Wilson Julie Gerardus Schouten 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20902 11604 Georgia Avenue Wheaton, Maryland Lance Antosz / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State in luny or 1 Burial 2 Cremation 3 Removal from State '4 Donation 5 Other (Speelly) Parklawn Memorial Park 10/15/04 Rockville, Maryland 22. Name and Address of Facility Hines Rinaldi Funeral Home 21. Signature of Funeral S wire Licensee 11800 New Hampshire Ave Silver Spring, MD 20904 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Myocardial Infarction Atherosclerosis Heart Disease disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Diabetes Mellitus II Sequentially list conditions, Dire to for as a nonsequence of Examiner cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed burial-transi Hypertension that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical Hypercholesterolemia the IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy 2 Fetal death 1 Live birth in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the signed by to be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No page 1 Yes To the Hospitel or Attending Physicien: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA 1 ☐ Yes 2 No Certification; To this. 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 X Natural 5 Pending М 1 TYes 2 No investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide Illed in within 24 hours a To the Funerel L 29a. Certifie ੱ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ((1) 74 (October 12, 2004 D26701 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11602 Georgia Avenue Wheaton, Maryland 20902 Kailash C. Chopra, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State oaks Paris Registrar OCT 1 4 2004

DHMH 17 Rev 1/2001

			State of Maryland / Department of Heal	Ith and Me	•	3
			Registrar Certificate of Dea		Reg. N	
	Physici /Media		1. Decedent's Name (First, Middle, Last) Patricia Marie Roller		43 1 1 .	ay Year 3. Time of Death p 16 2004 18:06 M
	Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Local			c. County of Death
			Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If U	111		Wiconica
	Funeral		Months Dave Ho	Under 24 Hrs. 8.	Date of Birth	Birthpue other unrorbign Country)
	Director		220-28-3876 1□ M 200 7rs. Months Days Ho Usual Residence of Decedent	ours wiiii.	Date of Birth (Month, Day, Yea 4-1-1934	Md.
	yland		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23a or 28a-1 show any injury or other traumatic svant, Ite M. dical Exa. ulnet must be multined at Once.	Funeral Director	De. Sussex Laurel	, born	*	1 ☐ Yes 2X No
	or 26	Olre	10e. Street and Number 10f. Zip Code		10g. C	citizen of What Country?
~	23a	<u>a</u>	12791 Trussum Pond Road 19956			USA
co Vy	r dea	ne	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispani If Yes, specify Cuban, Me	nic Origin? (Specify	y Yes or No-	14. Race - American Indian, Black, White, etc.
3 800	or it		1 Never Married 2. Married 1 yes 2. No		E-1, 0.0.,	
700	urai',	d by	3 Wildowed 4 Divorced Year or Dates:			Specify: White
~ ~ 7	"nat	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during life. DO NOT use retired)	g most of working	16b.	Kind of Business/Industry
212	withir ane. than	E	College (1-4or 5+)		T	rucking
	Hygie Hygie Ithar		12	Mother's Name /F	irst, Middle, Maide	n Sumama)
t or	od be	Be c			arbul Far	
Patal 220 Maryland	house d Me mark matic	2	19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street and N</i> .			
<u></u>	id 2 s Ith ar 27 is trau		M. Richard Roller, husband 12791 Trussum Po			De. 19956
<u>စ</u> ်	Hea Hea tem		20a. Method of Disposition 20b. Place of Disposition (Name of	Date	-	Location - City or Town, State
Baltimore,	ages ant of t: if i		A Dunial 2 Coloniation 5 Chantoval notification	10.00		
車	artme ortan injur		`4 Donation 5 Dother (Specify) DE. Veterans Memoria1 21. Signature of Funeral Service Licensee 22. Name and Address of F		U4 M1.	llsboro, De.
Ba	permi Depa Impo any ir		Short Funera	1 Homo		
			23a. Part1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line.	aurel D	e. 19956	Approximate
	Discontinuo					Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) a. ANOXIC ENCEPHAL of Due to (or as a consequence of):	OPATHY	<u> </u>	3 WEEK;
	Examiner		CARRIED FIT			7 52
		ē	Sequentially list conditions, If any leading to immediate Due to (or as a nonsequence of)			3 WEZY
	d ansit	Examiner	Sequentially list conditions, I any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.			
Ć,	be execui ician and burial-trar	Exa	resulting in death) Last Due to (or as a consequence of):			
760,	ate be executed nysician and he burial-transit	ical	d			
89	tificat g ph) as th					
Вох	n cert andin use	<u></u>	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery
m.	death e atte	ICla	in the past 12 months? 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 1 □ Yes 2 □ No 1 □ Live birth 2 □ Fetal death 5 □ Other (specify)			Month Day Year
P.O.	t the by th tache	Physician/Med	9 ☐ Unknown			
ď.	gned gned	ру Р	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in F	Part I.	23e. Did tobacco	use contribute to the cause of death?
ğ	n requires that the death certifica been signed by the attending ph should be detached for use as th		GASTNOWTESTINAL BLEED		1 ☐ Yes 2	No 3 Probably 4 dunknown
Division of Vital Records,	law re as be 2 sho	Completed	DIABETES		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Ä	ding Physician: The lav h. After this certificate has funeral director, page 2	Com	DISCITIS		performed?	death?
/ita	sian: ertific ector,	Be (examiner	Place of Death Ci		
<u>></u>	hysic his co	ို	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐	☐ Nursing Home	5 Residence	6 □Other (Specify)
n	ng P	on:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work?		Describe how inju	
si O	tendi eath tor: A	catl	2 Accident investigation M 1 Yes			
Ξ	or Ati	Certification;	4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f.	Location (Street as City or Town, State	nd Number or Rural Route Number, e)
	pital ours a aral [200 Codifice (Decidio Bhudain Thudain			
	To the Hospital or Attending Physicien: The law requires that the death certifica within 24 hours after death. To the Funaral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dated the composition of the basis of examination and/or investigation, in my opinion, and manner stated.	ite and place, and i, death occurred a	due to the cause(s it the time, date an	s) and manner as stated. d place, and due to the cause(s)
	o tha ithin o the omple	Mec	29b. Signature and title of certifier 29c. License numl	nber	29d. Da	ate signed (Month, Day, Year)
	ŏ + ≳ +		Politalla M.D. D2916			1.6/04
1 d	A A		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	9	/0	//6/0/
1000			A DAFAT ALLEN M. D. 1344 S. DIV.		(A :	10 40 21600
V	Sta	ite	ADBERT ALLEN M. D. 1346 S. DIVISIO. 31. Date filed (Month, Day, Year) OCT 18 2004 Server & Signature	31.	3/ -13/3	,
	Registr		OCT 18 2004 Preserve 19 Arm Val	,		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. 70. () 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Dey Month Year Velma L. Roper 2004 October 4:40 am 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Westminster Nursing and Convalescent Center Westminster Carrol1 If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. lest birthdey) If Under 1 Year 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) Months 1□ M 25€F Davs 246-32-2160 Usuat Residence of Decedent 81 May 20 1923 NC 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ➡No Carroll Westminster 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1234 Washington Road 21157 USA 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specify: 3 Vidowed 4 □ Divorced White 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Westminster Knit Elementary/Secondary (0-12) College (1-4or 5+) Company 8 Clothing/Textile 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Daniel Moses Cole Cora Lee Blankenship 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Maxie Philpot/daughter 138 City View Avenue Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pipe Creek Cemetery 10/13/2004 Linwood, MD 22. Name and Address of Facility Pritts Funeral Home and Chapel, P.A. 21. Signature of Funeral Service Licensee 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in deeth) Severe Due to (or as e consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ tonknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Physician /Medical Examiner

The law requires that the death certificete be executed

or Attending Physician:

director.

this

After

s efter death.

within 24 hours e Hospitai

the the

completely

Medical

Division of Vital Records, P.O. Box 68760.

Depertment or Important: If any injury or pace.

Physician

/Medical

Examiner

Funeral

Director

or 28a-f s

nit. Peges 1 end 2 should be filed within 72 hours after death with tenment of Heelth end Mental Hygiene.

ortant: If Item 27 is marked other than "natural", or Hema 23a or injury or other traumetic event, the Medical Examine must be a

Baltimore, Maryland 21215-0020

the Medical Examiner must be notified at

Director

Funerai

Completed by

Be

the Marylend

Examiner attending physician end for use es the buriel-transit Physician/Medical ed by the a signed b δ certificete has been si lirector, pege 2 should I Completed Be Certification: To filled in by the funerel

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last

TLI Yes 2LINO

1 ☐ Yes 2 ☐ No

	26. Place of Death (Check only one)												
l: 1 Inpatient	2 ☐ ER/Outpatient	3□ DOA	Other:	4 ☐ Nursing Home	5 🗆 Residence	6 □Other (Specify)							

1 Yes 2 No 27. Manner of Death 1 Naturel 5 Pending 2 Accident

25. Was case referred to medical

28a. Dete of Injury (Month, Day Year) investigetion 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifie (Check only one)

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier MO Seli

29c. License number D 52035 29d. Date signed (Month, Day, Year) 2004

30. Name end address of person who completed cause of death (Item 23e) (Type, Print) DINU CHAYO Stover

Westmunter

State Registrar

31. Dete fited (Month, Day, Year)

32. Registrar's Signature

2004

			1 - For State Registrer		arylaı			t of He		l Mental Hy	giene	004	34383
	Physici	an	Decedent's Name (First, Middle, L Orlando	ast) Romeo						2. Date of De		2004 ear	3. Time of Death 10:05 A M
	/Medio		4a. Facility Name (If not institution, g				4b. City,	Town, or L	ocation of De			County of Death	
	ZAGIIII		Stella Maris				Time	nium			В	altimore	3
	Funeral Director		5. Social Security Number 6. 218-41-3841 Usual Residence of Decedent	Sex 7. Ag 1 ☑ M 2 □ F 7.		last birthday) Yrs.	If Under Months		If Under 24 H Hours Mi		h y, Yea <i>r)</i>	9. Birth Cou	place (State or Foreign ntry)
	yiand how		10a. State 10b. County		10c. C	ity, Town or Lo	ocation						10d. Inside City Limits
	Be-fs	ctor		imore	OT	wson							1 □ Yes 2 No
	with the a or 2	Funeral Director	10e. Street and Number				10f. Zip				10g. Citi.	zen of What Cou Italy	ntry?
	death ms 23	eral	203 Garden Road 11. Marital Status	12. Was Decedent		J.S. 13.	Was Dece		panic Origin?	(Specify Yes or No- erto Rican, etc.)		14. Race - Ameri	
9	or its	/ Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give		1	lf Yes, spe 1 □ Yes	32	Mexican, Pur Specify:	erto Rican, etc.)		Black, White,	
21215-0036	be filed within 72 hours after death with the Maryland stal Hygiene. Individual instural, or Itams 23a or 28e-f show of other than "natural", or Itams 23a or 28e-f show event, the Medical Exer. it werenest be recified at	Completed by	3 Widowed 4 Divorced	Year or Dates:				al Occupati			1Ch Ki	Specify: Whi	
215	in 72 in "na Medic	plet	(Specify only highest g		5.\	(Give	kind of wo DO NOT u	rk done dui	ring most of w	vorking	16D. KI	nd of Business/Ir	dustry
21	filed with Hygiene. Ither than	Сош	8			Own	ner/O	perat	or			Tugboa	t
and	ed al	Be	17. Father's Name (First, Middle, Las					1		ame (First, Middle,			
Maryland		2	Giuseppe Rom 19a. Informant's Name/Relationship			19b. Mailir	ng Address	(Street and	Mari d Number or i	La (LIN) Rural Route Numbe	r, City or		Code)
Ž,	allth a		Salvatore Romeo	- Son						minster,		21157	
Baltimore,	Pages 1 an nent of Heal int: If item 2 iry or other		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3	☐Removal from State	20b.	Place of Dispo cemetery, crer	nsition (Nar	ne of ther place)		Date	20c. Lo	cation - City or To	own, State
Ħ			' 4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lic		Du.	laney V	alley	Mem.	Oct	. 11, 20)4 '	Timonium	, MD
Ba	permit. Departr Importi any inji		21. Signature of Furification Science	1300	_	4	12 Wa	ashino	rton Rá	l., Westm	eral inst	Home &	Chapel, P.A
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	y one cause on each II	ne. LE M a consec	TYELOMA quence of):	er the mod	le of dying,	such as cardi	ac or respiratory ar	rest,		Approximate Interval Between Onset and Death
68760,	ificate be executed g physician and as the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a consec	quence of):							
O. Box	that the death certific ed by the attending p detached for use as I	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Feta	aldeath 3□	Ectopic pr Other (sp				2	3d. Date of delive Month	ery Day Year
ords, P.	en signed	by	Part II. Dther significant conditions	contributing to death b	ut not res	sulting in the u	nderlying c	ause given	in Part I.				ne cause of death?
Vital Records,	The ate h	e Completed	25. Was case referred to medical						C Place of D		med? 2 X No	prior to co death?	psy findings available mpletion of cause of 2 No
of	ding Phys h. After this funeral dii	tlon: To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigati	Hospital: 1 Inpatie 28a. Date of Inju (Month, Da		ER/Outpatien 28b. Time of Injury		8c. Injury at Work?	4 🗆 Nursing	eath Check on or Home 5 Resid 28d. Describe h	ence 6	Contract (Specific occurred)	HOSPICE
Division	el or Attendi s after death. al Director: A ad in by the fu	Certification:	3 Suicide 6 Could not determine		ury - At h c. <i>(Speci</i>	ome, farm, str	eet, factory	, office		28f. Location (S City or Town	treet and n, State)	Number or Rura	l Route Number,
	To the Hospitel or All within 24 hours after or To the Funeral Direct completely filled in by	edical C	29a. Certifier (Check only one) 1 Certifying F 2 Medicel Ext	thysician: To the best iminer: On the basis of and manner sta	examina	owledge, death ation and/or inv	occurred vestigation,	at the time, in my opin	date and place ion, death occ	ce, and due to the courred at the time, d	ause(s) a ate and	and manner as si place, and due to	tated. the cause(s)
	To the within 2 To the complet	W	29b. Signature and title of certifier				290	License n	_		9d. Date	signed (Month,	Day, Year)
,	K.			11-				114	372	5	10	3/8/0	94
	B. Y		30. Name and address of person who DR. TARIO MAH			n 23a) (Type, NEY VA		RD -	ТТМОИТ	UM, MD 21	Uds		
B	Sta Registr	7.0	31. Date filed (Month, Day, Year)	2. 2004	r's Signa	ature				2.1			

DHMH 17 Rev 1/2001

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OCTOBER 7, 2004

ORLANDO ROMEO

			1- State of Maryland / Department of Health and Mental Hygiene Certificate of Death State of Maryland / Department of Health and Mental Hygiene Certificate of Death
	Physici	an	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year
	/Medio Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth
н	LXUIIII		19907 Old Midlothian Road Midlothian Allegany
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Day Year) 9. Birthplace (State or Foreign
	Director		215-16-43/1 / 83 115 15-Sep-1921 Maryland
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	Mary Fred	to	Maryland Allegany Midlothian № Yes 2 □ No
	or 286	lrec	10e. Street and Number 19907 Old Midlothian Road 10f. Zip Code 10g. Citizen of What Country?
	ath wi	ral	P.O. Box 382 21543- U.S.A.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Hitem 27 is marked other then "naturel", or Items 23a or 28e-f show mit pring or other treumatic event, I'te Madical Examinar must be notified at once.	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No Specify: Specify: White
2-0	72 ho	eted	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working) 16b. Kind of Business/Industry
12	hen hen	Completed	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)
	filed w Hygien Other ti		12 0 heavy equipment operator coal mining 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden, Sugarne)
and	d be f) Be	lors Clinton Pood
Maryland	should nd Men marke	ဥ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	and 2 ealth a n 27 is		Mary Margaret Reed wife 19907 Old Midlothian Midlothian Admid and
Baltimore,	es 1 a of Hei ritern		20a. Method of Disposition
<u>Ĕ</u>	Pages ment of i ent: If its ury or o		1 Seburial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Frostburg Memorial Park 20-Oct-2004 Frostburg Maryland
äalt	permit. Departimpo		21. Signature of Funeral Service Licensee 22. Name and Address of Facility
ш	₫ O = 9 0		Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532
	Physician /Medical Examiner		23a Parf1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a conse punctor): Sequentially list conditions,
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): d.
.O. Box 6		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1
rds, P	ires than signed at be de	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
<u>~</u>	The ate h page	Completed	24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 212 No 1 Yes 2 No
<u> </u>	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital: Other: Other:
	this aldii	lon: To	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 1 Natural 5 Pending 28b. Time of Injury (Month, Day Year) 28b. Time of Injury Work? 28b. Time of Injury Work?
_	tel or Attending Ph s after death. el Director: After th ed in by the funeral	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 6 Homicide 7 Homicide 7 Homicide 8 Homicide 7 Homicide 8 Hom
	To the Hospitel of within 24 hours af To the Funerel D	edical	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	Com, with	Σ	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
	4/1		71/ Mehange 1.9 2-(1) Cb October 14, 2004
7	This		29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCTO SEC OCTO
	Stat Registra	_	31. Date filed (Month Day, Year) OCT 1 92004 32 Registrar's Signature 9 Aparth

			State State Registrar	of Maryland / De	epartment of Certificate of		Mental Hyç	giene Reg. N2004	34385
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Virgil (nmn) Romes ber	.g			2. Date of Dea	Day Year	3. Time of Death
	Examin		4a. Facility Name (If not institution, give street and	number)	4b. City, Town,	or Location of Dea	th	4c. County of Dea	
				Jospital	Cum	ber la	UG	Allego	
	Funeral Director		5. Social Security Number 6. Sex 162 16 5717	7. Age (In yrs. last birtho	Months Davs			v. 917 VA	rthplace (State or Foreign ountry)
	ס		Usual Residence of Decedent	10c. City, Town					10d. Inside City Limits
	farylar e o a a l	ō	PA Somers et	Hyndman					1 Yes 2 No
	286-1	rect	10e. Street and Number		10f. Zip Code			10g. Citizen of What C	ountry?
	th with	al DI	830 Romesberg Road		15545			USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Items 23e or 28e-f ehow any injury or other treumetic event, i'm Medical Examinat must be notified at once.	by Funeral Director	1 Never Married 2 Married 11 Yes.	Decedent Ever in U.S. I Forces? es 2 □ No! 42 ~! 45 Give or Dates:	13. Was Decedent of If Yes, specify Cu		Specify Yes or No- rto Rican, etc.)	1.11.1.	
21215-0036	72 hou	ted	15. Decedent's Education (Specify only highest grade complete		Decedent's Usual Occu		orkina	16b. Kind of Business	s/Industry
21	nithin 7	Completed	Elementary/Secondary (0-12) Colleg	e (1-4or 5+)	ife. DO NOT use retir	ed)	9	D 11	
	Higen w Hygier ther ti	Co	17. Father's Name (First, Middle, Last)	$ Su_i$	oervisor	18. Mother's Na	me (First, Middle,	Rubber pr Maiden Sumame)	oduction
Maryland	lid be i lental i ked o ic eve	To Be	Frank (mnu) Romesberg				(mnu) Wer		
ary	and M and M Is mar	-	19a. Informant's Name/Relationship (Type, Print)		•			er, City or Town, State,	Zip Code)
	1 and Health Sm 27		Steven L. Romesberg 20a. Method of Disposition	20b. Place of D	O Romesber Disposition (Name of		lyndman,_	PA 15545 20c. Location - City of	r Town State
nor	ages ant of h it: If ite y or of		1 💢 Burial 2 □ Commation 3 □ Removal fr	om State cemetery,	crematory or other pl	·	16-2004	Hyndman. P	
Baltimore,	mit. P partme sorten / injur		21. Signa 11 (1 Funeral ervic Licensee	1000103	22. Name and Add	and the second s	10-2004	ngraman, r	^
Ö	Depa Impo any ir once		1 1/00					Home, Hynd	man, PA
	Physician		23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause immediate Cause Final disease or condition	on each line.	et enter the mode of dy			rest,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	to (or as a consequence of):	7			/
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs Cosessor in Jury	to (or as a consequence of):				
	eath certificate be executed attending physician and for use as the burial-transit	Examiner	that initiated events						
8760,	be exe ician a burial-	al Ex	Due	to (or as a consequence of):				
687	ficate g phys	edical	d						
Вох	death certific e attending p id for use as l	an/M	23b. was decedent pregnant	outcome of pregnancy ve birth 2 Fetal death	3 □Ectopic pregnan	cy		23d. Date of de	
О. Ш	5 a 5	Physician/Med	in the past 12 months?	regnant at time of death nknown	5 ☐ Other (specify)			Mortin	Day Year
۵.	res that the deligned by the bedeached		Part II. Other significant conditions contributing	to death but not resulting in t	he underlying cause g	iven in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
Vital Records,	- 07 73	ed by					1 □ Y	∕es 2□No 3□P	robably 4 Unknown
eco	e law requ has been ye 2 shouk	Completed					24a. Was autop	sy prior to	utopsy findings available completion of cause of
E B	Th ate pag	Con					perfor 1 ☐ Yes	rmed? death?	s 2□No
V Its	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	☐ Impatient 2 ☐ ER/Outp	patient 3 DOA	ther	eath (Check only of	ne) dence 6 □Other (Spe	20164
ion of	ding After fune	—	27. Manner of Death 28a. D	ate of Injury 28b. Tin	ne of 28c. Injury			now injury occurred	эспу
Division	n ite	Certification:	3 Suicide 6 Could not be determined 28e. P	lace of Injury - At home, farm uilding, etc. (Specify)	n, street, factory, office	Э	28f. Location (S City or Tow	Street and Number or F vn, State)	lural Route Number,
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edical (29a. Certifier (Check only one) Certifying Physician: To Certifying Phy						
	To the within 2 To the complete	Ä	29b. Signature and title of certifier			nse number		29d. Date signed (Mon	th, Day, Year)
	5		Christoplon A The	3 presi po	1000	05-9987	,	10.14.0	9
	nas		30. Name and address of Jerson who completed Christopher S. Wagnon; M.	900 .57	ype, Print) for Dr. Cu	mberhad	40 -		
	Sta			2. Registrar's Signature	bould				
	Regist								

DHMH 17 Rev 1/2001

			For Stete Registrer	State of	of Maryland	/ Depa	artment of H rtificate of L	lealth a Death	and M	ental Hygi	ene () () L	34387
Г	Dhusia		1. Decedent's Name (First, Midd	ile, Last)						2. Date of Death Month		V	3. Time of Death
	Physici /Medi		Ethyl Marion	Swann						October	22 ,	Year 2004	8:15 AM ^M
	Examir	ner,	4a. Facility Name (If not institution	. 3			4b. City, Town, or				4c. Count	y of Death	
			Calvert Memor			A 6 1-46 -1 - 3	Prince				Ca1	vert	
	Funeral Director		5. Social Security Number 139–14–0201	6. Sex 1 ☐ M 2 🛣 F	7. Age (In yrs. last	Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Birth (Month, Day, Nov. 23,	Year) 1919	9. Birthp Cour Tex	place (State or Foreign atry)
	and and		Usual Residence of Decedent 10a. State 10b. Count	у	10c. City, T	own or Lo	ocation						Od. Inside City Limits
	Mary 1 sh	ξ	Maryland Cha	arles	Нис	hesv	4110						1 XYes 2 □ No
	h the	Director	10e. Street and Number		Hug	,iics v	10f. Zip Code			10	g. Citizen of	What Cour	ntry?
	th wit	a D	17388 Teagues I	Point Road			20637				U.S.A	۸.	ŕ
	r dea	Funeral	11. Marital Status	12. Was Dec	edent Ever in U.S.	13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Ori	igin? (Spe	cify Yes or No-	14. Rac	ce - Americ	
36	within 72 hours after death with the Maryland ane. than "natural", or Items 23a or 28a-1 show the Marical Exemiter mat be mellined at	by Fu	1 ☐ Never Married 2 🛣 Ma 3 ☐ Widowed 4 ☐ Divorce	rried 1 Tes	2 XX No ve	1	1 ☐ Yes 2 【No	Specify:		ilouri, otc.,	Specif	ick, White, fy:	
9	tural			nt's Education		6a Dece	dent's Usual Occupa	ation		1		Whit	
21215-0036	d within 72 piene. r than "ne	Completed	(Specify only higher Elementary/Secondary (0-12)	est grade completed)		(Give	kind of work done of DO NOT use retired,	lurina mos	t of workin	g "	6b. Kind of B	ousinessand	dustry
212	77 70 2	E O	Elementary/Secondary (0-12)	College (1-40(5+)	Ho	me Maker				Own H	lome	
Maryland		Be (17. Father's Name (First, Middle	•				18. Mothe	r's Name	(First, Middle, Ma	aiden Sumar	me)	
yla	2 should be and Mental is marked o	ဥ	Marion Alfred	-						eatrice			
Nar	12 sh and is m		19a. Informant's Name/Relation				ng Address (Street a						
	ges 1 and 2 should it of Health and Mer if item 27 is marks or othar traumatic		Peter Swann /	Son	20h Place	17388	3 Teagues sition (Name of	Poin	t Ro	ad Hushe	sville	, Mar	yland 2063
Baltimore,	permit. Pages 'Department of H Important: If ite any injury or ot		1 X Burial 2 Cremation	3 □Removal from	State come	etery, crer	natory or other place	9)	Di	119 20	oc. Location -	- City or To	wn, State
퍒	permit. Pa Departmen Important: any injury		'4 □Donation 5 □ Other (: 21. Signature → -uneral Se	. //	Hunt	t Far	nily Cem.	o of Facilit	10-2	26-04	Waldo	rf, M	faryland
Ba	permi Depa Impo any ir		1 (0)	1511	401095	- D	. Name and Addres	70 To	y Br:	insfield	Funer	al Ho	ome, P.A.
			23a. Part1. Enter the disease, shock, or heart failure. Us			Do not ent	O. Box 2	, such as	cardiac or	respiratory arres	aryıan	id 206	Approximate
	Physician		Immediate Cause (Final	ACP	IRATION	. 4	PNEUM						Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. The Due to	(or as a consequent		110000				1 -		
þ.	Examiner		Sequentially list conditions	L. CH	RONIC	A	MUAL	F	BRU	LLATI	DN		
	D H	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(or as a consequent	ce of):				,			
	and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	(or as a consequence	ON	4						
8760,	icate be executed physician and the burial-transit	al E	,	Due to	(от аз а сопзециени	Ce or).							
687	ficate physis the	edlcal		d									
Вох	death certific e attending p id for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant		come of pregnancy						23d Dat	te of delive	n/
	0 0 5	icla	in the past 18 months?	4□Pregr	oirth 2 Fetal dea eant at time of death		Ectopic pregnancy Other (specify)						Day Year
P.O.	that the deatt ed by the atte detached for	hys	9 Unknown	9□ Unkn									
Ś	es gn be	by F	Part II. Other significant conditi	ons contributing to d	eath but not resulting	g in the ur	nderlying cause give	n in Part I.		23e. Did toba	cco use cont	ribute to the	e cause of death?
ord	w requir been si should	ted								1 Tes	2 200	3 Proba	ably 4 □Unknown
Sec	aw as b	Completed	-							24a. Was an autopsy		Were autop	sy findings available
a F										performe 1 ☐ Yes 2 ☐	No 1	death?	2 □ No
Vital Record		o Be	25. Was case referred to medical examiner?	Hospital:			Other	r		Check only one)			
o	Physic ruthis aral di		1 Yes 2 No 27. Manner of Death	28a. Date		Outpatien o. Time of	3 DOA	4 LI Nur		e 5 Residence Id. Describe how)
lon	nding Ph th. : After th s funeral	tlor	2 Accident 5 Pendii	ng (Mon	th, Day Year)	Injury	28c. Injury Work' M 1 □ Y	? es 2 □ N			injury occurr	00	
Division	or Attendate death	ifice	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be 28e. Place	of Injury - At home,	farm, stre	eet, factory, office		28	f. Location (Stree	et and Numb	er or Rural	Route Number,
	tal or A s after al Dira ed in b	Certification:	4 [] Nomicide	Dulida	ng, etc. (Specify)					City or Town, S	State)		1
	To the Hospital or Attending within 24 hours after death. To the Funeral Diractor: After completely filled in by the fune	edical	29a. Certifier 1 Certifying (Check only 2 Medical	ng Physicien: To the Examiner: On the ba	best of my knowled	ige, death	occurred at the time	e, date and	place, an	d due to the caus	e(s) and ma	nner as sta	ited.
	To the P within 24 To the F complete	Medi	57707	and main	ner stated.	aria/or irre			- Occurred				
	To To	~	29b. Signature and title of certifie	The d	MAIO		29c. License		011		Date signed	(Month, D	ay, Year)
, 1	m		ricum	OWI	IYIU			06	V 7.	TU	10/	27 (04
/ !) N		30. Name and address of person	who completed caus	e of death (Item 23a	a) (Type, I	Print) ROAD	DO	INIC-	E FRE	OFIR 10	16	MAD 2005
	Sta	te	31. Date filed (Month, Day, Year)	32 R	egistrar's Signature	LIT	C NUIDO	TIC	-1100	HRE	VVI		MD 2067
	Registr		OCT 2 5		in the	Sac	he						

State of Maryland / Department of Health and Mental Hygiene 2004 34388 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** October 14,2004 1405P /Medical ELIZABETH SANSBURY 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's County Hospital Cheverly Prince George's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2534F **Director** 217-30-0696 May 12,1909 Wash. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits ir then "naturel", or Items 23e or 28a-f ehow The Medical Examiner must be notified at 1. Yes 2 □ No Director Mitchellville MD Prince George 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? 10450 Lottsford Road Rm. 3-41 20721 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: δ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Law Firm 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be finance and Mental Figure 16 Carl Gilbert Bessie Whitney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1714 Swinburne Ave. (nt of Health at: If item 27 iv Patricia Turner/Niece crofton, MD 21114
20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 9 permit. Page Department of Importent: If any injury or once. Nat'l. Cem. 10/18/04 Suitland, MD Wash. 21. Signature of Funeral Service Licensee 23. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death

A L. Lacconstance of Complications and Complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death

A L. Lacconstance of Complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death

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A L. Lacconstance of Complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death

A L. Lacconstance of Complications that caused the death. Do 22. Name and Address of Facility Physician disease or condition resulting in death) /Medical **Examiner** lhzeimer's distase Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner burial-transit Due to (cras a construence of): that initiated events resulting in death) Last Physician/Medical wome anemia as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? Month Year Day 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel [29a. Certifier ե Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier. 29d. Date signed (Month, Day, Year) D42049 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Upper Marlboro MD 20772 CHAMPALOUX MD-6 Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 1 8 2004 Registrar

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SALSBURY

11	050		1- For Unpend Item 23ar	atero 18 Maryland / Di	कृत्रहुनुनानुष्यमुद्र <u>विध</u> ्वनुत्र् Pertificate of Death	Mental Hyg	giene	
			Decedent's Name (First, Middle, Last)			2. Date of Dea	ith 2004	3 3 3 3 9
	Physic /Medi		Vicki Denise Sp	rague		Month October	Day Year 24. 2004	1:35 P M
	Exami		4a. Facility Name (If not institution, give street	and number)	4b. City, Town, or Location of Dea		4c. County of Death	
0			2450 Shawnee Lane		Waldorf		Charles	
20	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 3 Usual Residence of Decedent	7. Age (In yrs. last birth)	Months Dave Hours Mir		7, Year) 9. Birth Court 7, 1964 Miss	place (State or Foreign intry) SOUNI
	aryland show		10a. State 10b. County	10c. City, Town o	r Location			10d. Inside City Limits
	ath with the Maryla 23a or 28a-f shows	to	Maryland Charles	Wal	dorf			1 □ Yes X No
	th the Ma or 28a-f	lrec	10e. Street and Number	- Maj	10f. Zip Code		log. Citizen of What Cou	intry?
	23a	a	2450 Shawnee Lane		20601		US	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It.e.M. dical Examiliate and the incilling anone.	by Funeral Director	1 Never Married 2 Married 1	as Decedent Ever in U.S. med Forces? Yes 2 X No Yes, Give par or Dates:	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2X No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Amen Black, White Specify:	
0-0	72 hol	Completed	15. Decedent's Education		ecedent's Usual Occupation		16b. Kind of Business/Ir	ndustry
215	within 7 ene. than "r r e Med	npie	(Specify only highest grade com Elementary/Secondary (0-12)	pleted) (C liii ollege (1-4or 5+)	Rive kind of work done during most of wo e. DO NOT use retired)	orking		,
2	ygien ygien yer th	So	12 2		Nurse		Hospice	
n d	be fill Hall Hall Hall Hall Hall Hall Hall H	Be	17. Father's Name (First, Middle, Last)		18. Mother's Na	me (First, Middle, i	Maiden Sumame)	
<u> </u>	nould I Mer narke	2	Harold Gene Sprague		Blanche	Demintin	ia Baldersor)
Mai	d 2 sh th and 7 is n traun		19a. Informant's Name/Relationship (Type, Pi Blanche D. Sprague -		ailing Address (Street and Number or R			Code)
Ġ,	1 an Heali em 2		20a. Method of Disposition	20b. Place of Di	Shawnee Lane, Wasposition (Name of		20601 20c. Location - City or To	owe State
ο̈́	ages ant of it: If if		1 XBurial 2 ☐ Cremation 3 ☐ Remov 4 ☐ Donation 5 ☐ Other (Specify)	al from State cemetery,	crematory or other place)			
Baltimore,	nit. Fiartme ortan injur	- 1	21. Signature of Funeral Service Licensee	1101001	er's Cemetert 10-	28-04 W	aldorf, MD	20601
ä	permit. Departimport. any inj		I for Hyden	- 1101331	duntt Funeral Home	dorf, MD	20604	
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau	s that caused the death. Do not		c or respiratory arre	20004 est,	Approximate
	Physician		Immediate Cause (Final	rcotic Intoxica	ation		y pilor d	Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence of):				
	Examiner	,	Sequentially list conditions, b					
	D #	iner	if any, leading to immediate cause. Enter Underlying Cause, Disease or injury	Due to (or as a consequence of):				
	ecute and -trans	Examiner	that initiated events c.	2				
8760,	icate be executed physician and the burial-transit			Due to (or as a consequence of):				
387		dicai	d.					
Box (eath certif attending for use as	/W	IF FEMALE: 23b. Was decedent pregnant 23c. if y	res, outcome of pregnancy			22d Date of deliver	-
P.O. B	t the d by the ached	Physician/M	in the past 12 months?		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive Month	Day Year
	es tha igned l	by P	Part II. Other significant conditions contributi	ng to death but not resulting in the	e underlying cause given in Part I.	23e. Did tob	acco use contribute to th	ne cause of death?
ord	v requir been si should l					1 ☐ Ye	s 2□No 3□Prob	ably 4 Unknown
of Vital Records,	The ate ha	Completed				24a. Was ar autopsy perform 122 Yes 2	/ prior to cor	psy findings available impletion of cause of
/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?		26. Place of Dea	ath (Check only one		
of	Physician: r this certific ral director,	2	1 No Hospita	1 Inpatient 2 ER/Outpai		iome 5 Reside	nce 6 Other (Specify	, scene
on c	ding F	ion	1 □ Natural 5 □ Pending Fo	Date of Injury 28b. Time Found	y Work?	28d. Describe ho	w injury occurred	
Division	or:	icat	3 Suicide 6 Could not be	-24-2004 1:30	A M THES ZX NO	Unknown		
Σİ	7 8 7 7	Certification:	4 Homiciae	Place of Injury - At home, farm, building, etc. (Specify) ene		City or Town	eet and Number or Rura State) 2450 Sha	awnee Lane,
	To the Hospital c within 24 hours af To the Funeral D completely filled in	aic	29a. Certifier 1 Certifying Physician:	To the best of my knowledge, de	ath occurred at the time, date and place	Waldorf,		ated
	the Ho hin 24 th the Fu	ledical	(Oriser of ity 2 Examination Chariffel Of	n the basis of examination and/or d manner stated.	investigation, in my opinion, death occu	rred at the time, da	te and place, and due to	the cause(s)
	To the within To the Comp	X	29b. Signature and title of certifier		29c. License number	29	d. Date signed (Month, I	Day, Year)
			· unest		OCME		October 25,	2004
(В		30. Name and address of person who complete				23,	2001
	Sta Registr	_	31. Date filed (Month, Day, Year) OCT 2 5 2004	32. Figistrar's Signature		LIZUI		

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** DOROTHY SACREY OCT. 7:30 A M G. 2004 12, /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner WILSON HEALTH CARE CENTER **GAITHERSBURG** MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
NOV. 26, 1 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 ☐ M 217 F Yrs. 89 Director 577-07-8806 1914 VIRGINIA Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits in than "natural", or items 23a or 28a-f show the Medical Evander must be notified at 1 XYes 2 □ No Director MD. MONTGOMERY **GAITHERSBURG** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 301 RUSSELL AVE. #419 20877 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if tiem 27 is marked other than "natural", or tles may injury acother traumatic event, the Medical Evanta 1 ☐ Yes ② No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ Specify: **¾** Widowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) WILLIAM L. **GOLLADAY** LULA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BRUCE C. SACREY SR./SON 17424 PARK MILL DR., DERWOOD, MD. 20855 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY | 10-14-2004 RIVERDALE, MD. 22 Name and Address of Facility 21. Signature of Funeral Service Licensee CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 M00091 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA Priysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner led by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Box 68760 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 Yes 2 2No Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ð 1 ☐ Yes 2 🗙 No 3 Probably 4 Unknown Completed RTENTION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No STEOPOROSIS 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other 4 Nursing Home 5 | Residence 6 | Other (Specify) 1 ☐ Yes 2 No 27. Manner of Death To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier emuy GEORGIA AVE, SILVER SPRING MID 2002 (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death , MD ENURY 31. Date filed (Month, Day, Year)
OCT 14 32. Registrar's Signature 14 Registra

			1 - For Stete Registrar	state of Maryland / Depa Cea	artment of Health and M Artificate of Death	ental Hygie	2004 34391			
	Physic /Medi		Decedent's Name (First, Middle, Last) Sarah Shapiro			2. Date of Death Month	Day Year 3. Time of Death			
	Exami		4a. Facility Name (If not institution, give stree Suburban Hospital	et and number)	4b. City, Town, or Location of Death	October	4c. County of Death			
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday) 2 XF Yrs.	Bethesda If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye				
	ryland how		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation	Jul 12,	1915 New York 10d. Inside City Limits			
	h the Ma or 28a-f s	Director	Maryland Montgome:	cy Chevy C	hase 10f. Zip Code	10g.	1 X Yes 2 □ No Citizen of What Country?			
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-1 show aumatic event, the Madical Examiner must be notified at	Funeral D	8100 Connecticut A		20815 Vas Decedent of Hispanic Origin? (Spef Yes, specify Cuban, Mexican, Puerto I	cify Yes or No-	USA 14. Race - American Indian,			
5-0036	ours after ral', or the Examina	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐ Yes 2 ☑ No	r Yes, specify Cuban, Mexican, Puerto I I ☐ Yes 2 <mark>17</mark> No <i>Specify:</i>	Rican, etc.)	Black, White, etc. Specify: White			
21215-0	ithin 72 h	Completed	15. Decedent's Educati (Specify only highest grade of Elementary/Secondary (0-12)		ent's Usual Occupation kind of work done during most of workir OO NOT use retired)	16b	. Kind of Business/Industry			
ğ	m - 0 2	Be Con	12 17. Father's Name (First, Middle, Last)	• '	inistrative Assist	ant (First, Middle, Maid	USPO den Sumame)			
Maryland	permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 le marked o any injury or other traumatic even	To	Harry Kazkewitz 19a. Informant's Name/Relationship (Type,	Print) 19b. Mailin	Edtta Le	VINSON Route Number, City or Town, State, Zip Code)				
re,	s 1 and 2 f Health a item 27 l		Bob Kott/Son in Law 20a. Method of Disposition	2326 20b. Place of Dispos	Blane Dr, Chevy Ch	ase, MD 2				
Baltimore,	artment o		W Burial 2 □ Cremation 3 □ Rem. '4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses	Beth Mose	s Cemetery Oct 1	2. 2004	Pinalaum NV			
ñ	Dep Imp		23a. Party Enter the disease, or complicati	<i>H</i> 11	Name and Address of Facility Hine 800 New Hampshire	Ave. Silv	ver Spring, MD 20904			
	nysician /Medical	8 1	shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death) a	Pneunoni		respiratory arrest,	Approximate Interval Between Onset and Death			
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	kecuted and I-transit	Examiner	if any, leading to immediate cause. Enter Underlying that initiated events cresulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):						
09/80	icate be executed physician and s the burial-transit	dicalE	d	out to (or as a consequence on).						
. DOX	death certif e attending id for use as	Physician/Me	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year			
cords, P.	law requires that the as been signed by the 2 should be detached	by	Part II. Other significant conditions contribu		derlying cause given in Part I.		o use contribute to the cause of death? 2 🛣No 3 □ Probably 4 □Unknown			
בֿ ,	The faw req	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?			
A	ding Physician: The h. After this certificate h. funeral director, page	o Be C	25. Was case referred to medical examiner? 1 □ Yes 2X No Hosp	tal: 1X Inpatient 2 □ ER/Outpatient	26. Place of Death					
	ding Phy th. : After thii : funeral c	\vdash		Ba. Date of Injury (Month, Day Year) 28b. Time of Injury		e 5 ☐ Residence id. Describe how inj	6 ☐Other (Specify) ury occurred			
	io the nospiral or Attending Physician: within 24 hours after death. To the Euneral Director: After this certification of the physician is completely filled in by the funeral director; is	ertification;	3 Suiside 6 Could not be	Be. Place of Injury - At home, farm, stree building, etc. (Specify)		f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)			
	strongerial and special and sp	edical C	E Interior	n: To the best of my knowledge, death on the basis of examination and/or invented manner stated.	occurred at the time, date and place, an estigation, in my opinion, death occurred	d due to the cause(at the time, date ar	s) and manner as stated. nd place, and due to the cause(s)			
,	withii comp	W	29b. Signature and title of certifier	2	29c. License number		ate signed (Month, Day, Year)			
	フ		30. Name and address of person who comple				October 11, 2004			
	Stat Registra		Joanna W. Kir, MD 31. Date filed (Month, Day, Year) OCT 14 2004	1201 Seven Locks Ros	d; Pockville, MD 2085 Aparks	4.				

			1 - State Registrar	State of Ma	aryland / Depa <i>Cei</i>		of Health a	nd Me		2001	4 (34392
	Physicia	an.	Decedent's Name (First, Middle, Last)		-				Date of Death			3. Time of Death
	/Medic	cal	Leo 4a. Facility Name (If not institution, give str	Sudzi	n	4h City T	own, or Location of		October	13, 20 4c. County of		3:16 a M
	Examin	ier	Suburban Hospita				n e sda	Death		Montg		у
	Funeral Director		5. Social Security Number 6. Sex 1色 N	7. Age	e (In yrs. last birthday) 86 Yrs.	If Under 1 Months	Year If Under 2 Days Hours	Min.	Date of Birth (Month, Day, Y	1917 g	Birthpla Country New	ce (State or Foreign York
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation					100	d. Inside City Limits
	Maryla fed a	ğ	Maryland Montgomer	v	Silver Spr						100	1 ☐ Yes 2 No
	th the	Olrec	10e. Street and Number	J		10f. Zip C			100	J. Citizen of Wha	at Countr	y?
	s 23a	ral	10010 Kinross Avenu		7		20901			USA		and a
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deportment of health and Mentalle Hygiene. Importent: If item 27 is marked other than "natural," or Items 23a or 28a-f show any njury or other treumatic event, Ite Madical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ▼ Widowed 4 □ Divorced	. Was Decedent & Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:	lo l	was Decede If Yes, specif 1 ☐ Yes 2	ent of Hispanic Orig by Cuban, Mexican, Who Specify:	en? (Specif , Puerto Ric	y Yes or No- can, etc.)	14. Race - Black, Specify:	White, et	C.
5	72 hou nature	eted	15. Decedent's Educa (Specify only highest grade of	tion completed)	16a. Dece	dent's Usual kind of work	Occupation done during most	of working	16	b. Kind of Busin	ness/Indu	stry
7	within and the within and the within and the within a wit	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)	DO NOT use Econor	retired)	or working		US Gov	ernm	ent
7	illed v I Hygie other i	Be Co	17. Father's Name (First, Middle, Last)			ECOHOL		's Name (F	First, Middle, Ma			
) la	Menta Menta arked atic ev	To B	Phillip Sudzin				Anna	Gelf	und			
2	12 sho h and 7 Is mu treum		19a. Informant's Name/Relationship (Type Ursula Lowenstein/			-	Street and Number					and 20901
ָ ט	Healt Healt tem 2		20a. Method of Disposition		20b. Place of Dispo	sition (Name	9 of	Date		c. Location - Ci		
2	Pages ont: If		†⊞Burial 2 ☐ Cremation 3 ☐ Rer '4 ☐ Donation 5 ☐ Other (Specify)	noval from State			netery 1	.0/15/	2004 A	delphi,	Mar	yland
Daltillo	permit. Departm Importe any inju		21. Signature of Funeral Service Licensee	man	22	. Name and	Address of Facility	Hine	s Rinal			
	ST SE		23 Part1. Erter the disease, or complica shock rheart failure. List only one	itions that caused cause on each lin	the death. Do not ent	er the mode	of dying, such as c	cardiac or re	espiratory arres	e	lr Ir	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Encepha								Onset and Death
	Examiner				a consequence of): .c Cardiony	opathy	v					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		a consequence of):		,					
	ecuted and I-trans	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as	a consequence of):						10	
,00,0	icate be executed physician and s the burial-transit	dlcal E	L _d									
00	E O B	0	IF FEMALE:									
. DO	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 54 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physiclan/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	: If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal death 3	Ectopic pred Other (spec				23d. Date of Month	, , ,	ay Year
Ţ.	s that the ned by a detact	by Ph	Part II. Other significant conditions contr	buting to death be	ut not resulting in the u	nderlying cau	use given in Part I.		23e. Did toba	cco use contribu	ute to the	cause of death?
Š	equire sen sig ould b	ted t							1 🗆 Yes	2 XNo 3[☐ Probab	ly 4 □Unknown
מטים ו	The law rate has be page 2 sh	Completed							24a. Was an autopsy performe 1 □ Yes 2∑	d? prio	r to comp th?	y findings available idetion of cause of
A 11.0	icien: certific rector,	Be	25. Was case referred to medical examiner?	spital:			Othor		Check only one)			
5	g Phys er this eral di	n: To	27. Manner of Death	28a. Date of Injur	ry 28b. Time of		c. Injury at Work?		5 Residence d. Describe how			
5	anding lath. pr: After he funer	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da)	Year) Injury	M	work/ 1 ☐ Yes 2 ☐ N	lo				
2	or Atter de Direct de Lin by t	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubuilding, etc	ury - At home, farm, str c. (Specify)	eet, factory,	office	28f	Location (Stree City or Town, S	et and Number (State)	or Rural F	Route Number,
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	Medical Co	29a. Certifier (Check only one)	r: On the best of and manner sta		occurred at vestigation, i	t the time, date and n my opinion, death	place, and h occurred	I due to the caus at the time, date	se(s) and manno and place, and	er as state I due to th	ed. ne cause(s)
	To the within To the Complete	Me	29b. Signature and title of certifier Alpaaly	ma	i M.D.		License number D27660			Date signed (A		
	Į v		30. Name and address of person who com Alpana Goswami, M.		eath (Item 23a) (Type, Rockville		#G100 Ro	ckvil	le, Mar	yland 2	0852	
	Sta Registr		31. Date filed (<i>Month, Day, Year</i>) OCT 1 4 2004	32. Begistra	ar's Signature	Space	Kal					

DHMH 17 Rev 1/2001

Amend #20b &20c 10/14/ per Fun.Dir. AACounty Dept. lo

17. Father's Name (First, Middle, Last)

Toddie E. Green

Chambers MD

19a. Informant's Name/Relationship (Type, Print)

Bart M. Griffin (Son)

Physician /Medical Examiner

Funeral Director

0/14/04													
	e Type or Pr	int in Blac	ck Ind	delible	Ink.	Ensu	ire Al	I Copies	Ar	e Leg	ible.		
1 - For State Registrar	State of N	Depa <i>Cer</i>	rtment tificate	04	3439	3							
1. Decedent's Name (First, Middle,	Last)							2. Date of Do		Dav		3. Time of Dea	ıth
Jean G. T	vler							Octob		. ,	Year 2004	6:00	MC
4a. Fecility Name (If not institution,		r)		4b. City, T	Town, or	Location of	of Death			4c. Count	y of Death	'	-
906 South Wie	eker Road		Ì	Set	/err				7	Anne	Arur	ndel	
		ige (In yrs. last b	irthday)	If Under 1	1 Year	If Under		8. Date of Bi	rth		9. Birthp	lace (State or Fo.	reign
215-34-5724	1 ☐ M 2 ☐ XF	67	Yrs.	Months	Days	Hours	Min. J	(Month, D	a <i>v, Y</i> e 3	1937	Cour	Zland	
Usual Residence of Decedent						-							_
10a. State 10b. County		10c. City, Tox	n or Lo	cation							1	0d. Inside City Li	mits
Maryland Anne	Arunde1	Seve	rn									1 ⊡ k∳es 2 ⊡]No
10e. Street and Number				10f. Zip Code					10g. Citizen of What Country?				
906 South Wid	eker Road			211	44						Ţ	JSA	
11. Marital Status	13. V	Vas Decede	ent of His	panic Ori	gin? (Spe	ecify Yes or No)-		ce - Ameno				
1 Never Married 2014 Married		If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc.											
3 ☐ Widowed 4 ☐ Divorced	1	1 ☐ Yes 2 ☐ No Specify: Specify: Black						ick					
15. Decedent's (Specify only highest)	(Give I	cedent's Usual Occupation ve kind of work done during most of working						Business/Ind	dustry				
Elementary/Secondary (0-12)	life. L	O NOT use	e retired)				Ar	nap	olis	Federa	1		
12th	Cook												

18. Mother's Name (First, Middle, Maiden Sumame)

Lola Price

906 South Wieker Road Severn, Md. 21144

2002 Medical Pky Sute 350 Annapolis MD21401

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exam natural barrollina at once.

To Be Completed by Funeral Director

Physician /Medical **Examiner**

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 2 should be detached for use as the burial-transit

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specif	Removal from State	Place of Disposition (cemetery, crematory	or other place)	Date 0/18/	Cross	ocation - City o	r Town, State		
	21. Signature of Funeral Service Licer	me Me o 483	Wm.	Veteran 1 a and Address of Facility Reese & S West St.				i01		
cai Examiner	23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Einter Underlying Cause (Disease or righry final interval Between Consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 5 □ Other (specify)									
ompiered	ASTIMA					1 ☐ Yes 2 24a. Was an autopsy performed? ☐ Yes 2 Novo	24b. Were a prior to death?	utopsy findings available completion of cause of		
D P	25. Was case referred to medical			26 Place o		ack only one)	1 1 1 1 1 1 1 1	2 2 140		
	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2[TER/Outpatient 3D	Other			6 DOING (C-			
Medical Certification: 10	27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. 0	d. Describe how injury occurred				
Cerunc	3 Suicide 6 Could not by determined	28e. Place of Injury - At building, etc. (Spec	home, farm, street, fac cify)	tory, office	28f. L	ocation (Street ar lity or Town, State	d Number or R	ural Route Number,		
edicai	29a. Certifier (Check only one) (Check only one)	ysician: To the best of my kr niner: On the basis of examin and manner stated.	nowledge, death occurr nation and/or investigat	red at the time, date and join, in my opinion, death	place, and di occurred at	ue to the cause(s the time, date and	and manner a place, and du	s stated. e to the cause(s)		
Σ	29b. Signature and title of certifier			29c. License number		29d. Da	te signed (Mon	th. Day, Year)		
	· Lone	Llom		D4810	01		10	-14-2004		
	30. Name and address of person who	completed cause of death (Ite	em 23a) (Type, Print)					0		

State Registrar

		Please Type or Print in).
		1- State of Maryla State of Maryla		tificate of			200!	+ 34394
Physicia /Medic	al	Decedent's Name (First, Middle, Last) Nancy Mae Thomas				2. Date of Death Month OCT 1	Day Ye	
Examin	er	4a. Facility Name (If not institution, give street and number) CIVISTA MEDICAL CENTER		4b. City, Town, or LAPL	r Location of Death ΛΤΛ		4c. County of D	
Funeral Director			. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y Oct. 5, 1	CHARI 9.1 950 Ma	5 E S Birthplace (State or Foreign Country) 1 ine
aryland show	_		ity, Town or Lo	cation				10d. Inside City Limits
the M	Director	Maine Penobscot Net	wport	10f. Zip Code		100	. Citizen of What	1 Tyes 2 No
23a ol	alDi	405 Williams Road		04953			nited St	•
is 1 and 2 should be filed within 72 hours after death with the Maryland s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If the Arris marked other than "neturel", or Itams 23a or 28a-f show other treumatic event, the Medical Examinar must be inclined at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in the Armed Forces? 1 ☐ Yes ≥ ☑ No If Yes, Give Year or Dates:	J1	Vas Decedent of Hi f Yes, specify Cuba ☐ Yes 2 \ No	ispanic Origin? (Spe in, Mexican, Puerto I Specify:	ocify Yes or No- Rican, etc.)		merican Indian,
72 hou		15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ent's Usual Occupa	ation	16	b. Kind of Busine	Mite ss/Industry
within ene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)			during most of workii	ng		
Lal yidild Kild	Be Co	17. Father's Name (First, Middle, Last)	Carqu	est Deli	very 18. Mother's Name	(First, Middle, Mai	Auto iden Sumame)	Parts
2 should be and Mental is marked of eumatic even	To E	Harry Sanborn		ı		u Robert		
National Shart Shart Strient Treum		19a. Informant's Name/Relationship (Type, Print)			and Number or Rura			, Zip Code)
permit. Pages 1 and 2 Department of Health s Importent: if item 27 is any injury or other tre	3	Edward Mack Thomas-spouse 20a. Method of Disposition 20b.	Place of Dispos	IIII3IIIS B sition (Name of natory or other place	load, Newp	ort, Mai	ne 04953 Location - City	or Town, State
Page tment tent: If tent: If jury or		`4 □Donation 5 □Other (Specify) Hu	ntt Cre			-2004 Wa	ldorf. N	Marvland
Departing Department Departmen		21. Signature of Funeral Service Licensee M01246	TI	Name and Addres	s of Facility			
Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consection)	th. Do not ente	O. Box 1 or the mode of dying	56, Waldo g, such as cardiac of	rf, MD 20 respiratory arrest,	0604-015 tial	Approximate Interval Between Onset and Death
Pa icia B	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consect of the						
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Physicia this certi	0	25. Was case referred to medical examiner? 1 □ Yes 2 □ No Hospital: 1 ☑Inpatient 2 □	ER/Outpatient	04-	26. Place of Death	(Check only one) e 5 ☐ Residence	6 FlOther (Se	ooifid)
ng Ph fter th	Certification: T	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	28b. Time of Injury	28c. Injury Work		3d. Describe how in		вспу)
tal or Att	Certifi	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At h. building, etc. (Specification of the state of the st	ome, farm, stree	et, factory, office	28	Bf. Location (Street City or Town, St	and Number or F ate)	Rural Route Number,
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To t To t Com	Σ	29b. Signature and title of certifier () ()		29c. License	number	29d. I	Date signed (Mor	th, Day, Year)
		20 Name of addings of assessment assess of death //	- 00-1/7 =		56949	10	116/01	t
DD 16		30. Name and address of person who completed cause of death (Item KAMAKSHI BAIG MD 6620 CRA		,	102 TATE	[A [] A 3.4.75	0011	
State	~	31. Date filed (Month, Day, Year) OCT 1 8 2004 32. Figistrar's Signa	ture	SULLE-	102 LAP	LAIA MD	20646	
Registra		001 1 0 2004	(1) Ag			_		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For Amend Item 2	State of Ma 3b-c.pt.I	ryland / 1,25,27	Depa 28a Ceri	rtment of H - f per m e tificate of l	lealth and N B G843 5- Death	/lental Hyd -6-05 ta	giene IS Reg. No. 'O	0.1	01.005
П			Decedent's Name (First, Middle, Last						2. Date of De	ath 120	UH	3. The of Cate J
	Physicia /Medic		John Vernon Trainor Octol								Year 04	3:40 M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County o	f Death		
			Washington Adv		*			ma Park		Montgomery		
	Funeral		Social Security Number 6. S	ex 7.Age S∑M 2⊡F	(In yrs. last bi		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	Date of Birth (Month, Day, Year) 9. Birthplace (State or F Country)		
	Director		218-18-4794 Usual Residence of Decedent		91	Yrs.			Sept. 1	8, 1913	Mar	yland
	Mo #		10a. State 10b. County		10c. City, Tov	vn or Loc	ation				1	0d. Inside City Limits
	Mary fied	ō	Maryland Montgo	omerv	Silv	er S	pring					1 ☐ Yes 2 🛣 No
	r 28a	Directo	10e. Street and Number	<u>-</u>			10f. Zip Code			10g. Citizen of W	hat Coun	try?
	deeth with the Marylend rns 23e or 28a-f show r nust be nutting at		9907 Edgehill Lar	ne			20901			USA		
	deeti	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S.	13. W	as Decedent of Hi	ispanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No	- 14 Race	- Americ	
20	172 hours after deeth with the Marylen "natural", or Items 23e or 28a-f show selical Examinating at	by Fu	1 ☐ Never Married 2 ☐ Married 3 【S Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	lo		□Yes 2톤 No	Specify:		Specify:	T-71- 4	
2-003e	72 hou	ted	15. Decedent's Ed	ducation	168	. Deced	ent's Usual Occupa	ation during most of work	king	16b. Kind of Bus	iness/Ind	dustry
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and	be filed ntal Hygi ed other event, i	Be	17. Father's Name (First, Middle, Last)							Maiden Sumame)	
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a)	es 1 end 2 should be of Heelth and Mental fitem 27 is marked o r other traumatic eve		John Henry Traino 20a Method of Disposition	r/ Son	20h Place	of Disnos	ition (Name of	L Lane, S	Date	pring, M 20c. Location - C		
E E	mit. Pages I partment of H sortent: If ite r injury or ot		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		Par	ктаw	atory or other place n Memori	aı:	ber 16,	Pockeri 1 1	lo M	Marriand
Saltil	permit. Page Department Importent: If any injury or once.		21. Signature of Funeral Service Licer				rk Name and Addres	ss of Facility.		Rockvill		aryland
ñ	Departiment of the services once.		Most 6	()M .		50	O Univer	sity Blv	funeral d, W, Si	l ноте ir ilver Spi	nc. cinq	MD 20901
			23a. Part. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death. Do	not ente	r the mode of dyin	g, such as cardiac	or respiratory ar	rrest.		Approximate Interval Between
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Rox		Z/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy					23d. Date	of delive	гу
	death e atte	icia	in the past 12 months? 1 □ Yes 2 □ No	1☐Live birth 4☐Pregnant at			Ectopic pregnancy Other (specify)			Mont	th	Day Year
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ğ	w require been si should b		Diabetes, Hypoth	yroidism					1 0 1	/es 2 □ No 3	Prob	abiy 4 XUnknown
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0	Phyel this c al dire	2	1 X Yes 2 No		nt 2 ER/O	utpatient	3 DOA Othe			dence 6 Other		")
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2	pitel or a	Serti	4 Homicide	at home	c. (Specity)				Silver	Spring M	rag D	eniii Lane
	s Hospitei 24 hours e Funerai etely filled		29a. Certifier 1∑ Certifying Ph (Check only 2 ☐ Medical Exar	ysician: To the best on the basis of	of my knowledg	ge, death	occurred at the timestication in much	ne, date and place,	and due to the	cause(s) and man	ner as st	ated.
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	To Too	2	29b. Signature and title of certifier				29c. License			29d. Date signed		
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			30. Name and address of person who					- #020	m - 1-	D- 1. 150		17.0
	01-	40	Kempanna Sudhak 31. Date filod (Month, Day, Year)					e, #230,	rakoma	rark, MD	209	112
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Department Dep				1 - For State Registrar	7,8sigeroBiviation		tificate of			Reg. No. U U 4	34396
April Apri		Dhuaini		1. Decedent's Name (First, Middle, I	ast)			-	2. Date of Dea	ath	
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College (1-4cr 5+) Similar (2-4cr 5+) Similar	الله و ك	or Ite			Armed Forces? 1 ☐ Yes 2 ▼No	'	res, specify Cut	ban, Mexican, Pue	rto Rican, etc.)	Black, W	
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Due to (or as a consequence of): Comparison of the control of t	F		ē	Sequentially list conditions, if any, leading to immediate	b. Dye to (or as a conse		NIGI	C NOT		Moule	
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The past 12 months? 23c. If yes, outcome of pregnancy 23d. Date of delivery 23d. Date of delive	O, 0	eg <u>⊢</u>	_		Due to (or as a conse	equence of):	0.1-(0		111	8	
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Of Date Bad Mark Day Verd				30. Name and address of person who	completed cause of Aeath (Ite	m 23a) (Type, P	rint)	001	CLE	20111.0	7121
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		1 - For State Registrar	State of I	Marylan				lealth a Death	and M	lental Hy	giene Reg. N	711111	34397
		1. Decedent's Name (First, Middle, La	ast)	Total						2. Date of De	ath		3. Time of Death
Physic /Med		Dim:	itrios I.	ISIPO	ouras					Month 10	08		
Exam		4a. Facility Name (If not institution, gi Montgomery Gen					Town, or	Location of	of Death			ontgomer	
Funera Director			Sex 7. 1 X M 2 □ F	Age (In yrs. 56	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Da 04-14	ay, Year,) Co	hplace (State or Foreigr buntry) LECE
pu *		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
faryla show	5	,											1√2 Yes 2 □ No
the N	Director	MD Montgor 10e. Street and Number	пету	DI	ookevi	10f. Zip	Code				10g. Ci	tizen of What Co	puntry?
3a or	Ö	21211 Georgia	Avenue				20833	3			Unit	ted Stat	es
ING X IX I 3-0030 be filed within 72 hours after death with the Maryland tal Hygiene. d other than "naturel", or items 23a or 28a-f show event, the Modical Expir infinitels be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Amed Force 1 Yes 2 If Yes, Give Year or Date	s? ∑No		Was Dece f Yes, spe 1 Yes	Y	ispanic Ori n, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)		14. Race - Ame Black, White	ncan Indian,
Maryland 21215-0036 d 2 should be filed within 72 hours aft lith and Mental Hygiene. 77 is marked other than "naturel, or traumatic event, the Medical Expri	Completed	15. Decedent's Elementary/Secondary (0-12)	ducation rade completed) College (1-40	or 5+)	16a. Deced (Give life.	dent's Usu kind of wo DO NOT u	al Occupa ork done d se retired	ation during mosi ()	t of worki	ing	16b. K	(ind of Business/	Industry
filed will Hygien other th	Con	7			Real	Estai	e Ir			(****		eal Esta	te
be fill had he out	Be	17. Father's Name (First, Middle, Las								(First, Middle			
re, Marylan s 1 and 2 should be t Health and Mental item 27 is marked of other traumatic eve	ဥ	Ilias K. Tsipoura			19h Mailir	na Address	(Street a			Papado		LOS or Town, State, 2	Zin Code)
Ma nd 2 s lith an 127 is		Vasiliki Tsipoura				_						e, MD 20	
Baltimore, Misper Band 2 Department of Health a Important: If item 27 is any injury protible tra		20a. Method of Disposition 153 Burial 2 Cremation 3 Control of Co	☐Removal from Sta	20b. F	Place of Disponentery, crem			е))ate		ocation - City or	
nit. P artme ortan		21. Signature of Funeral Service Lice		. G	ate of			s of Facilit				lver Spr Funeral	
D Ped of S		+ Dust	Mend	lon-									g MD 20904
Physician /Medica Examinei		23a. Part1. Enter the disease, or cor shock, or peart lailure. List ont Immediate Cause (Final disease or condition resulting in death)	one cause on each	card as a conseq	ial I	nfar	ctio	<u>n</u>		respiratory a			Approximate Interval Between Onset and Death MITURES
8 / 6U, cate be executed physician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a conseq	uence of):	ara			<i>y</i>	7/3-0-03			guris
O. BOX 6 ne death certific the attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcor 1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknown	n 2∏Feta tat time old	Ideath 3	Ectopic p Other (sp						23d. Date of dell Month	ivery Day Year
d ba	þ	Part II. Other significant conditions	contributing to deat	h but not res	ulting in the u	nderlying o	ause give	en in Part I.			tobacco Yes 2		the cause of death?
Z 2 6 5	Completed					_				24a. Was auto perfo		prior to o	stopsy lindings available completion of cause of
VITAI sicien: T certificate irector, pa	Be C	25. Was case referred to medical						26. Place	of Death	(Check only	-/-		
<u>←</u> ≥ ∞ P	To	examiner?	Hospital: 1 ☐ Inp		ER/Outpatier			4 1140				6 ☐Other (Spec	cify)
te ig		27. Månner of Death 1 Natural 5 Pending 2 Accident investigati	on	njury Day Year)	28b. Time of Injury	м	28c. Injury Work 1 ☐ `	∕at ⟨? Yes 2 □ I		28d. Describe	how inju	ry occurred	
Division of or Attending s after death. I Director: Afte	Certification:	3 Suicide 6 Could not 4 Homicide determine	289. Place of	Injury - At he , etc. (Specif		eet, factor	y, office			281. Location (City or To			iral Route Number,
To the Hospitel or / within 24 hours after To the Funerel Dire	Medical C		hysicien: To the beaminer: On the basis	s of examina									
To the within 2 To the complet	Me	29b. Signature and title of certifier				29	c. License	number			29d. Da	ite signed (Month	h, Day, Year)
1		> ellelele	ilialan	<u> </u>		D	002	842	9	1	Octi	ober 8, a	1004
*		30. Name and address of person who	completed cause of	ol death (Iter	п 23а) (Туре,	Print)		11		1 1	¥1121	Prince	Phillip Drive and 20832
		Phyllis E. Nich	150H N	100150 istrar's Signa	mery	v-en	eral	118	pita	1 /	1010	Maria	and sove
S Regis	tate trar	OCT 14 20	na La	war	9	Ann	1/2	,		Oi	ny	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	The sould be

			For State Registrer	State of Marylan		artment rtificate				ntal Hy	Reg. Ro.	004	34398
	Physicia /Medic Examin	al	Decedent's Name (First, Middle, Las Robert James 4a. Facility Name (If not institution, give	Townsend				Location of		oct.	13°,	2004 County of Death	6:15 Рм
*	Funeral Director		203 32 3030	ex	last birthday) Yrs.		CKVI 1 Year Days	If Under 2 Hours	Min	Date of Bi (Month D	rth	9. Birth	y place (State or Foreign intry) nsylvania
	e Maryland a-f ehow lifted at	ctor	Usual Residence of Decedent 10a. State 10b. County MD Howard		y, Town or Lo Lghland								10d. Inside City Limits 1 ☐ Yes 2☐ No
	35 or 28	I Dire	10e. Street and Number 7137 Deer Valley	Road		10f. Zip	2077	77			-	ed State	-
020	be filed within 72 hours after death with the Maryland Hygiene. d other then "naturel" or items 23g or 28s-f ehow event, it a Medical Enathret must be trollified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No 1964 If Aes, Give Year or Dates: 1965	<u>-</u>	Was Deced If Yes, spec		spanic Orig n, Mexican, Specify:	gin? (Specit , Puerto Ri	fy Yes or N can, etc.)		4. Race - Amer Black, White Specify: Whi	, etc.
21213-0030	i within 72 hc jene. r then "netul it s Medical	Completed	15. Decedent's E. (Specify only highest grade) Elementary/Secondary (0-12)	ducation (de completed) College (1-4or 5+)	(Give	edent's Usua e kind of wor DO NOT us YSTEMS	k done d e retired,	luring most)				nd of Business/li	
land.	be d d	To Be C	17. Father's Name (First, Middle, Last, Robert Francis To	_				Geo	orgia	First, Middle Leisl	ner		
Baltimore, Mary	permit. Pages 1 and 2 should be Department of Health and Mental Importent: If item 27 le marked any injury or other treumatic events.		19a. Informant's Name/Relationship (Bryan Robert Tow 20a. Method of Disposition 1X Burial 2 Cremation 3 C 4 Donation 5 Other (Specif	msend/son Removal from State St	P.O. Place of Disponentery, cree	Box 2 position (Name of the control	238, ne of ther place etery	High 7 10	land, Dat 0/16/2	MD 2 te 2004	20777 20c. Loc Clar	cation - City or T	own, State
pal	Depar Impor any in		23a. Part1. Enter the disease, or comshock, or heart failure. List only	- With lo	4	112 01	ld Co	olumb:	ia Pk	. Ell:	icott	e's Fam City, I	ily FH, Inc MD 21043
,	Physician // Medical Examiner physician and physician and physician and physician signature it ansignature in the physician and physician and physician are physician and physician are physician and physician are physician and physician are physician and physician are physician and physician are physician are physician and physician are	lical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Metastatic (Due to (or as a consect b. Due to (or as a consect c. Due to (or as a consect d.	Cancer quence of):								Onset and Death
O. Box 6	it the death certifica by the attending ph tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Feta 4 Pregnant at time of o	al death 3	□Ectopic pr					2	23d. Date of delin Month	very Day Year
ds, P.	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions	contributing to death but not re	sulting in the	underlying c	ause givi	en in Part I.			tobacco u Yes 2		the cause of death? obably 4 Hunknown
Records,	The ate h page	Completed								24a. Wa auto per 1 Yes	s an opsy formed? 2 No	prior to c death?	topsy findings available completion of cause of 2 No
ion of Vital	ding PI h. After ti funera	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time Injury		8c. Injun Worl	er: 4 □ Nu	rsing Home	(Check only e 5 Res	sidence 6		Hospice
Division	in Dirt	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	nome, farm, s	treet, factor	y, office		28		(Street and own, State,		ral Route Number,
	To the Hospitel within 24 hours a To the Funerel I completely filled	edical (29a. Certifier 1 Certifying P (Check only one) 1 Medical Exe	hysicien: To the best of my kn miner: On the basis of examin and manner stated.	owledge, dea ation and/or i	ath occurred investigation	at the tin	ne, date an pinion, dea	d place, an	nd due to the d at the time	e cause(s) e, date and	and manner as place, and due	stated. to the cause(s)
		Me	29b. Signature and title of certifier	Ma		290	c. Licens	e number	18		29d. Dat	e signed (Manth) (A Day, Year)
10	Str. Regist	ate	30. Name and address of person who Charles Harrison 31. Date filed (Month, Day, Year)	6001 Muncast	er Mil	1 Rd.		ckvil	le, M	D			

			1- State of Maryland / Dep	artment of Health and N rtificate of Death		2004	34399
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici		Kenneth Antonio Tamargo		October	Day Year	07:45 AM
	/Medio Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			615 Lombard Road	Rising Sun		Cecil	
_	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birth	place (State or Foreign intry)
	Director		218 72 2123 XDM 2□F 45 Yrs.		Jan. 9,		land
	pur *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	sho	'n					1 ☐ Yes 2 🕅 No
	the N	Director	Maryland Cecil Rising St	10f. Zip Code	10	Og. Citizen of What Cou	untos?
	with	Ω					•
	ns 23	era	615 Lombard Road 11. Marital Status 12. Was Decedent Ever in U.S. 13.	21911 Was Decedent of Hispanic Origin? (Sp		nited State	
•	r iten	Funerai	Armed Forces? 1 □ Never Married 2 Married V□ Yes 2 □ No 1987 —	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	
ž	el', o	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 1988	1 ☐ Yes 2X☐ No Specify:		Specify: Wi	nite
- -	tiled within 72 hours after death with the Maryland Hygiene. Ither than "neturelt, or items 23e or 28e-f show ent, I'te Madical Exand act must be notified at	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Giv	dent's Usual Occupation	ina 1	6b. Kind of Business/I	ndustry
Z	thin 19	npie	Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of work DO NOT use retired)	g		
7	ed w ygien ner th	Sol		Fighter		Air Force	
ב	tal H d oth	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name		faiden Sumame)	
<u>Ş</u>	should be filed within nd Mental Hygiene. marked other then umatic event, I to M	Ţ	Alfred S Tamargo II	Sandra H			
Maryland 21215-0036	d 2 st h and 7 is n treun			ng Address (Street and Number or Rum ombard Road, Risin			
	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Department of Healih and Mentle Hygiene. Department of Healih and Mentle Hygiene. The most interest is marked other than "neturel," or frems 23e or 28e-f show any injury or other treumetic event, the Medical Experiment must be notified at once.		9 .			Oc. Location - City or T	
Battimore,	Pages nent of ant: If it		T Bunar 20 Cremation 3 Annovarion State				
	artme orten injury		/ 114) - 1 - 4 - 4 - 4 - 4 - 4 - 4 - 4 - 4 - 4	e Crematory Oct.		Newark, Del	aware
g	permit. Departr Importe any inje			7 South Main Stree			and 21901
			23a. Part1. Enter the disease, or complications that caused the death. Do not en	·			Approximate
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	0			Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a. Huntington's Due to (or as a consequence of):	115458			years
	Examiner						
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
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Š	e exection a		Due to (or as a consequence of):				
8/6U	cate be executed physician and s the burial-transit	dicai	d				
×	ding p	63	IF FEMALE: 23c. If yes, outcome of pregnancy				
ROX	atten for us	Physician/M	in the past 12 months?	□Ectopic pregnancy □ Other (specify)		23d. Date of deliv Month	ery Day Year
o.	the de	ysic	1 Yes 2 No 9 Unknown				
J.	The law requires that the death certifi te has been signed by the attending l bage 2 should be detached for use as	/ Ph	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did toba	acco use contribute to t	he cause of death?
Vital Records,	uires la sign	d by			1 ☐ Yes	s 2 No 3 □ Prol	oably 4 Unknown
000	w require been sign should b	iete			24a. Was an	24b. Were auto	ppsy findings available
Ψ Υ	hysicien: The law his certificate has b il director, page 2 si	Completed			autopsy	prior to co death?	mpletion of cause of
		0	25. Was case referred to medical	26. Place of Death	1 Yes 2	XNo 1 ☐ Yes	2 100
=	ysici is cer direc	To B	examiner? We yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	Othon		nce 6 ☐Other (Specia	5v)
0	ng Phys ter this neral dir		27. Manner of Death 1, X Natural 5 ☐ Pending 28a. Date of Injury 28b. Time of Injury 1, Injury 28b. Time of Injury 28b. Time	f 28c. Injury at Work?	28d. Describe how	v injury occurred	
<u> </u>	ttending Phy death. :tor: Atter thi the tuneral o	atic	2 Accident investigation	M 1 Yes 2 No			
DIVISION	or Atta	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	eet and Number or Rura State)	al Route Number,
2	olfel c urs af rel D lled ir			*			
	Hosp 14 hou Fune fely ti	lcai	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, deat (Check only one) 4 Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, a vestigation, in my opinion, death occurr	and due to the cau ed at the time, dat	use(s) and manner as s te and place, and due t	tated. the cause(s)
	To the Hospitel or Attending Physicien: within 24 hours state deals. To the Funerel Director: Attent his certific completely tilled in by the tuneral director,	Medicai	one) and manner stated. 29b. Signature and title of certifier /	29c. License number	290	d. Date signed (Month,	Day, Year)
	5 1 E 1		M Manden Ma	7,5214		ctober 13.	22224
			30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	V	1100417,	2007
15	THIVA		H Farkas. MD Union Hospita	P. Elkton MD	21921		
	Sta	tę	H Farkes, MD Union Hospita 31. Date filed (Month, Day, Year) 32. Registrar's Signature OCT 1 5 2004	. ,			
	Registr		OCT 1 5 2004 Keeps & Aprile				

			For State Registrar	State of Man		epartment of F Certificate of			giene	11114	34400
ı	Physicia	an	1. Decedent's Name (First, Middle, La	st)				2. Date of De Month	Day	y Yea	3. Time of Death
	/Medic		Ronald Charles					Octobe		1, 2004	
	Examin	er	4a. Facility Name (If not institution, give				Coxing	1		County of De	
			Holy Cross Hospi 5. Social Security Number 6.3		n yrs. last birt	Silver	If Under 24 Hrs.	8. Date of Bir		ontgome	irthplace (State or Foreign
	Funeral Director			OXM 2□F 59		rs. Months Days	Hours Min.	Feb. 19	y Year)	945 Wa	Country) ashington, DC
	ъ		Usual Residence of Decedent								
	anylar show	<u>-</u>	10a. State 10b. County		Oc. City, Town						10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	8a-1:	ecto	Maryland Montgo	nery	llver	Spring			40.00		1
	with th	吉	10e. Street and Number			10f. Zip Code 20906			-	izen of What (200
	ns 23	eral	2307 Kenosha Pla 11. Marital Status	12. Was Decedent Eve	or in U.S.	1	Hispanic Origin? (S	pecify Yes or No		ted Sta	nerican Indian,
2	r Iten	Funeral Director	1 Never Married 2 X Married	Armed Forces? 1 X Yes 2 No		13. Was Decedent of H If Yes, specify Cubi		o Rican, etc.)		Black, Wh	nite, etc.
Š	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show snt, the Marical Examiner mat be confilled at	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1968	1 ☐ Yes 2 X No	Specify:		1	<i>Specity:</i> Af ric ar	n American
ה ה	72 ho	Completed	15. Decedent's E (Specify only highest gr		16a.	Decedent's Usual Occup (Give kind of work done	during most of wor	king	16b. K	ind of Busines	ss/Industry
7	vithin ne. han	mp	Elementary/Secondary (0-12)	College (1-4or 5+)	Sc	`life. DO NOT use retired oldier	d)		11 (S. Army	*
7	Hygie Hygie ther t nt, ID		12 17. Father's Name (First, Middle, Lasi)	1 50	rurer	18. Mother's Nar	ne (First, Middle,			y
5	d be antal	o Be	Charles Upshur	,				e McNair		,	
	shoul nd Me mark	유	19a. Informant's Name/Relationship	Type, Print)	19b.	Mailing Address (Street				or Town, State	, Zip Code)
Ž	nd 2 sith ar 27 is r trau		Yvonne S. Upshur	(wife)	23	307 Kenosha	Place, S	ilver Sr	ring	e. MD	20906
, ח	of Her		20a. Method of Disposition		20b. Place of cemeter	Disposition (Name of y, crematory or other place	ce)	Date		ocation - City o	or Town, State
2	Page nent c int: If		1 X Burial 2 A Cremation 3 E 1 Donation 5 ☐ Other (Speci	THEIIIONAL HOILI STATE		ngton Nation		27/04	Arl:	ington	, VA
Daltillo	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Modical Examilited matter of the modified at once.		21. Signature of Funeral Service Lige	nsee	-	22. Name and Addre					
_	9 Q E 2 9		Cholre Sho	mpson		7400 Georg	gia Ave.	N.W., Wa	shi	ngton,	D.C. 20012
	_		23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused the one cause on each line.	e death. Do n	ot enter the mode of dyir	ng, such as cardiad	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a. Acute Re	enal Fa	ilure					days
	/Medical Examiner		resulting in death)	Due to (or as a co		,					_
		<u></u>	Sequentially list conditions, if any, leading to immediate	b. Upper ga		ntestinal bl	eeding				days
	nted I Insit	mine	Cause (Disease or injury	c Coagulor							days
ŕ	execun n and ial-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a co		of):		-			uays
0000	w requires that the death certilicate be executed been signed by the attending physician and should be detached for use as the buriat-transit	edical	(d. Diabetes	Melli	tus					years
0	ntifica ng ph as th		IF FEMALE:								
Š	ath ce ttendii or use	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p	Fetal death	3 Ectopic pregnancy	y			23d. Date of d Month	elivery Day Year
;	the all	/slcl	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tim 9□ Unknown	e of death	5 Other (specify)				W.Gitta:	July 15th
Ĺ	hat the		Part II. Other significant conditions	contributing to death but n	ot resulting in	the underlying cause giv	en in Part I.	23e. Did to	obacco u	use contribute	to the cause of death?
Š	sign*	d by				, , ,		101	Yes 2	□No 3□1	Probably 4\(\frac{1}{2}\)Unknown
colus,	w request	Completed			-			24a. Was	an	24b Were	autopsy findings available
ב ב	raician: The law s certificate has t director, page 2 s	ш						autop perfo	rmed?	prior to death?	completion of cause of
N I G	an: T lificat or, pa	o l	25. Was case referred to medical				26 Place of Dea	1 ☐ Yes		1 □ Ye	es ŽQ No
	ysicia is cer direct	To B	examiner? 1 ☐ Yes 2 XNo	Hospital: 1 X Inpatient	2 ER/Out	tpatient 3 DOA Oth	0.00	lome 5 Resid		6 ☐ Other (Sp	pecify)
5	ding Physician: The Ih. After this certificate he funeral director, page		27. Manner of Death 1 XNatural 5 Pending	28a. Date of Injury (Month, Day Ye	28b. T	ime of 28c. Injur		28d. Describe t			
VISIOU	endir eath. or: Af he fui	atlc	2 Accident investigation	n		M 1 🗆	Yes 2 □ No				
<u> </u>	br Att	ertiflcation;	3 Suicide 6 Could not lead to determine determined		- At home, fai Specify)	rm, street, factory, office		28f. Location (5 City or Tox			Rural Route Number,
ב	pital	O	29a, Certifier 1 X Certifying P	hygiciag. To the best of a	ny kaomindan	dooth converse at the time	data and place	and due to the			
	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical		hysicien: To the best of n miner: On the basis of ex and manner stated	amination and						
	ro the vithin ro the complex	Me	29b. Signal are and title of certifier			29c. Licens	se number		29d. Dat	te signed (Moi	nth, Day, Year)
	6+1		A	Vauraz		D50	987.			-13-0	
	V ,		30. Name and address of person who	completed cause of deat	h (Item 23a) (15-a-1-				
			AHMED NAWA	12 10 BOX	858	14 Gal	ners b	mg 1	עני	2008	2
	Sta Registr		31. Date filed (Month, Day, Year) OCT 15 2	32. Registrar's	Signature	5 Spark	2				
	negisti	aı	001 195	004		//					

DHMH 17 Rev 1/2001

Registrar

	,		State of Maryland / Department	artment of Health and M	ental Hygiei Reg.	
Н	Physicis	an	1. Decedent's Name (First, Middle, Last)			Day Year 3. Time of Death
	Physicia /Medic	al	Charles Roy Wilhelm, Jr.			22, 2004 658 a M
	Examin	er	4a. Facility Name (If not institution, give street and number) 1-70 at Route 97	4b. City, Town, or Location of Death Cookesville		4c. County of Death Howard
ı			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		8. Date of Birth	
	Funeral Director		219-34-1383 ^{1⊠M 2□ F} 66 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Sept. 22,	1938 Maryland
-	9		Usual Residence of Decedent			
-	arylar show	_	10a. State 10b. County 10c. City, Town or L			10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	28e-1	ectc	MD Baltimore Monkt	10f. Zip Code	100	Citizen of What Country?
	with with	늡	16920 Big Falls Road	21111		U.S.A.
1	ns 23	Funeral Director		Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I		14. Race - American Indian,
3	s 1 and 2 should be filed within 72 hours after death with the Maryland of Heath and Mental Hygiene. If Heath and Mental Hygiene. If marked other then "natural, or items 23s or 28e-f show other treumetic event, the Modical Examinations be notified at	by	1 □ Never Married 2 X Married 1 X Yes 2 □ No	If Yes, specify Cuban, Mexican, Puerto I 1 ☐ Yes 2X No Specify:	Hican, etc.)	Black, White, etc. Specify: White
	natura lical B	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation	16b	. Kind of Business/Industry
1	ithin 3e.	nple	Fiamentary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of workin DO NOT use retired)	1	Insurance
7	iled w tygier her th		17. Father's Name (First, Middle, Last)	.ms Manager	(First, Middle, Maid	
2	d be fi	9 Be	Charles L. Wilhelm, Sr.		Billings	
	shouk nd Me mark metic	은		ing Address (Street and Number or Rura		
2	nd 2 still ar ar ar treu		Doris A. Wilhelm/Wife 1692	20 Big Falls Rd.	, Monkt	on, MD 21111
ַ נ	of Heat item othe		20a. Method of Disposition 20b. Place of Disposition carmetery, cre	osition (Name of matory or other place) Oct.	27 20c	Location - City or Town, State
₫ .	Page nent c ent: If ury or		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) **Method:**	n United 2004		Monkton, MD
Dall	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tre 00028.		21. Signature of Funeral Service Licensee	2. Name and Address of Facility J.J. Hartenstein 24 Second St., N	Mortua	ry, Inc.
	12.17		23a. Parti, Enter the isease, or complications that caused the death. Do not en shot, or he wifailure. List only one cause on each line.	ter the mode of dying, such as cardiac o	r respiratory arrest,	Approximate Interval Between
F	Physician			Iniulies		Onset and Death
	/Medical		disease or condition resulting in death) Due to (or as a consequence of):	-11/01/05		
k	Examiner		Sequentially list conditions, b.			
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Under in Cause (Disease or injury			
	xecut and al-trar	xan	that initiated events c. resulting in death) Last Due to (or as a consequence of):			
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	that ti ed by detac		Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
cords,	luires n sign uld be	d by			1 ☐ Yes	2 No 3 Probably 4 Unknown
5	w requir s been si should l	Completed			24a. Was an	24b. Were autopsy findings available
ב	The faw ate has page 2 :	E O			autopsy performed 1XYes 2	
		Be C	25. Was case referred to medical examiner?	26. Place of Death		
5	Physiclen: this certifica ral director, p	10	1 XYes 2 No Hospital: 1 Inpatient 2 ER/Outpatie			6 DOther (Specify) at scene
=	fter	-Co	27. Manner of Death 1 □Natural 5 □ Pending 28a. Date of Injury (Month Day Year) Injury	Work?	28d. Describe how in	1 1 1 1
2	ttend death ttor: /	icat	2 Accident investigation 1/12/04 6:42 3 Suicide 6 Could not be 289 Place of Injury - At home farm of			TO Involved in Collision
2	after Direc	Certification:	3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide	1	City or Town, Si	TAU ROTE 97
	To the Hospitel or Attending Physiclen: White 24 hours after deals. To the Funerel Director. After this certification of the funerel Director. After the formal director, to the funeral director.	dical C	29a. Certifier (Check only Check on	th occurred at the time, date and place, a	and due to the cause	
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
	~ s ⊢ ö) Mill	OCME		October 22, 2004
		l i	30. Name and address of person the completed cause of death (Item 23a) (Type	111 Penn Stree	t, Baltim	nore, Maryland 21201
	Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Sparke		
	Regist		OCT 2 8 2004 Seneva 19	pours		
2111	4H 17 Roy 1/2		001 /			

Projection Pro				1 - For State Registrar	State of Maryland	d / Departme <i>Certifica</i>	nt of Health and ate of Death		giene 0	04	34403
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The part of the pa		ath w	<u>a</u>								
The part of the pa		tems	une	TI, Walland States	 Was Decedent Ever in U.S Armed Forces? 	3. Was Dec	edent of Hispanic Origin? (ecify Cuban, Mexican, Pue	Specify Yes or No- into Rican, etc.)			
The part of the pa	36	or l	Ϋ́		If Yes, Give	1 ☐ Yes	2 No Specify:		Speci	fy: TuTh f	ito
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The part of the pa	<u>.</u>	n 72 "na "na	jet	(Specify only highest grad		(Give kind of v	vork done durina most of w	orking	TOD. KING OF E	0031110552111	dustry
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Steven B. Webster, Sr. (father) Steven B. Webster, Sr. (father)		filled Hygi Sthar			0			am <i>e (First, Middl</i> e, I	Maiden Suma	те)	
Steven B. Webster, Sr (Father) 6631 Oak Ridge Drive, Hebron, Maryland 21830 20a. Memod of Disposition 1.6 Burst 20 Chostion - City or Town, State 1.6 Donation 5 Date 20 Chostion - City or Town, S	lan	ld be ental ked c	OB	Stavon B.	Webster, S	Sr.	Anne	Eliza	beth	R	obbins
The state of the s	2	shou nd M mar mar	-	550,00							
The Bursal 2 Commands Command		nd 2 Ilth a 27 is r tra		Stoven B Webster.	Sr (father)	6691 Oak	Rida Drive	Hebron.	Marula	nd 2	1830
Solution Solution	ē,	f Heal		20a. Method of Disposition	20b. Pla	ace of Disposition (A	ame of				
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Provision Medical Examiner The part of th	ñ	Dep Part Part Part Part Part Part Part Part		North 11 A	truner (FSF	_					
The proposed of the property of the past 12 months? Due to (or as a consequence of):				23a. Part1. Enter the disease, or compli	cations that caused the death.	. Do not enter the m	or of dying, such as cardia	ac or respiratory arre	est,	агала	Approximate
Due to (or as a consequence of): Due to (or as a consequence of):				Immediate Cause (Final	e cause on each line.	1. 12 Co A C	- J. L				Onset and Death
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30. Name and address of person who completed cause of death (Item 23a) (Type. Print) JOSON EVANS 223 Phillip Morris Dr. Salisbury Mp 21804		t hou unal	cai	29a. Certifier 1 Certifying Phys (Check only 2 Medicel Exemit	icien: To the best of my know ter: On the basis of examination	rledge, death occurre on and/or investigation	d at the time, date and place, in my opinion, death occ	e, and due to the ca	iuse(s) and ma	anner as st	ated. the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type. Print) JOSON EVANS 223 Phillip Morris Dr. Salisbury Mp 21804		the hin 24 the F	ledi	one)	and manner stated.						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State 31. Date field (Month, Day, Year) OCT 1 4 2004 32. Redistrar's Signature OCT 1 4 2004		Vit To Con	2	29b. Signature and title of certifier		2	9c. License number	29	d. Date signe	a (Month, l	Jay, Year)
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State 31. Date fied (Month, Day, Year) 32. Redistrar's Signature & Sports						23a) (Type, Print)	morris or.	Salisbu	y mp	210	904
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			1 - For State Registrer	State of Marylan	-	artment of H			20 () 4	3440	4
	Physici	ian	1. Decedent's Name (First, Middle, Last)	Mehster				2. Date of Death Month	Day 12	24	3. Time of Dea	ath M
	/Medic Examir		4a. Facility Name (If not institution, give s	WEDET G.	-	4b. City, Town, or	Location of Death		4c. County	of Death	0.00	
	Funeral Director	ler	Peninsula legiona 5. Social Security Number 6. Sex	1 Nedical Ce	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2/ Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	Wic (ear)	9. Birth	olace (State or Fo ortry) yland	reign
	pu s		Usual Residence of Decedent 10a. State 10b. County	10c Cib	y, Town or Lo	ocation					IOd. Inside City L	imite
	the Maryis 28a-f sho	Director	Maryland Wicomico 10e. Street and Number		oron	10f. Zip Code		100	ı. Citizen of \		1 □ Yes 2 5	
	Mith Ba or		6691 Oak Ridge Dri			21830		109	USA		itty:	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 28s-f show my highly or other traumatic event, its Modicel Exacting renal be retilified at ances.	by Funeral		2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:			ispanic Origin? (Specin, Mexican, Puerto F	ify Yes or No- lican, etc.)	14. Rac	ce - Americk, White,		
21215-0036	within 72 ho ene. than "natur ive Medical I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occupa kind of work done o DO NOT use retired	during most of workin	g 16	b, Kind of B	usiness/In	dustry	
121	filed w Hygier other th		17. Father's Name (First, Middle, Last)	0		infant	18. Mother's Name	/First Middle Ma	infan			
Maryland	should be find Mental H marked of umatic ever	To Be	Steven B.	Webster, S			Anne	Elizab	eth	R	obbins	
Mar	d 2 sho th and t7 is m traum		19a. Informant's Name/Relationship (Ty)				and Number or Rural				1830	
	Pages 1 and nent of Health int: If item 27 iry or other tr		Steven B. Webster, 20a. Method of Disposition 1 XBuriai 2 Cremation 3 R 4 Donation 5 Other (Specify)	emoval from State	lace of Dispo emetery, cren	sition (Name of matory or other plac	Da	ite 20	c. Location -	City or To	own, State	
Baltimore,	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service License		Ħ	orloway f	wheral Ho Will Road,	me Profe	ssiona	al As	sociatio	
68760,	Examiner Systems and Systems a	icai Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underflying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	uence of):	rematur	;+y				Interval Between	
O. Box	ne death certifics the attending pt hed for use as t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 ∐Live birth 2 ∏ Fetal 4 ∏ Pregnant at time of do 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Dai	te of delive	ery Day Year	
a	quires that the signed by and be detacted	þ	Part II. Other significant conditions con	tributing to death but not resu	ulting in the u	nderlying cause give	en in Part I.	23e. Did tobac	cco use cont		ne cause of death	
I Records,		Completed						24a. Was an autopsy performe	d2 (prior to co death?	psy findings avai mpletion of cause 2 No	lable of
Vital	Jing Physician: The Arter this certificate funeral director, pag	Be	25. Was case referred to medical examiner?	ospital:		0.5	26. Place of Death					
of	Physic rthis ral dir	5	1 ☐ Yes 2 ☑ No 27. Manger of Death	1 Impatient 2	ER/Outpatien 28b. Time of		4 🗀 Nuising Hom	e 5 🗌 Residend 3d. Describe how			y)	
Division	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could ning be	28a. Date of Injury (Month, Day Year)	Injury ome, farm, str	M 1 🗆	res 2 □ No	Bf. Location (Stree	et and Numb		il Route Number,	
Ö	s afte	Cert	4 Homicide	building, etc. '(Specify	/)			City or Town, S	otate)			
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical (29a. Certifier (Check only one) 1 ✓ Certifying Phys 2 ☐ Medical Examir	ician: To the best of my kno- ler: On the basis of examinal and manner stated.	wledge, death tion and/or inv	n occurred at the tim vestigation, in my op	ne, date and place, ar pinion, death occurre	nd due to the caus d at the time, date	se(s) and ma and place, a	inner as s and due to	tated. the cause(s)	
•	To t To t	Σ	29b. Signature and title of centrer			29c. License			Date signed	. /	Day, Year)	
			Jason Ev	mpleted cause of death (Item 2015 23	23a) (Type. <i>Ph//</i>	Print) Mon	058997 ris Or. 30	Visb urg	, mu	d	1804	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	Sound	2					
	· region	171	OCT 1 4 20	J4 ()	~	The same						

			For Amend Item	State of Marylar 19a per INF.	nd / Departme , G853, 03//2 <i>Certifica</i>	nt of Health and 7/06dhb/gs te of Death	Mental Hygie	2004	34405
			1. Decedent's Name (First, Middle, Last)	A 1			2. Date of Death Month	Day_ Year	3. Time of Death
and.	Physicia /Medic		Darlene	Adam	5		October	-25,200	4 2:05 M
7	Examin	er	4a. Fecility Name (If not institution, give s	street and number) #	A1 4b. City	, Town, or Location of Dea	th	4c. County of Deati	1
			5. Social Security Number 6. Sex	7. Age (In yrs	last birthday) If Und	er 1 Year If Under 24 Hrs		9 Birti	nplace (State or Foreign untry)
	Funeral Director			IM 200 40	Yrs. Months	Days Hours Min	Month, Day, Y	1963 Mi	aryland
	pu »		Usual Residence of Decedent 10a, State 10b, County /	10c C	ity. Town or Location				10d. Inside City Limits
	shov	'n	10a. State 10b. County	1	R (1 + 1)	1050			1 XYes 2 □ No
	28a-f	Funeral Director	10e. Street and Number		101. 2	ip Code	10g	. Citizen of What Co	untry?
	h with	ie D	1613 Futan	Place #	All	21217		USI	7
	ems 2	iner	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13. Was Dec	edent of Hispanic Origin? (Secrety Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White	
36	s afte	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes	200 Specify:		Specify: 72	lank
5-0036	72 hours after death with the Maryland natural, or Items 23e or 28e-1 show iteal Examener must be motified at	ted t	15. Decedent's Edu	cation	16a. Decedent's Us	ual Occupation	16	b. Kind of Business/	ndustry
215	within 72 ene. than "na	Completed	(Specify only highest grade	completed) College (1-4or 5+)	(Give kind of w	rork done during most of wo use retired)	orking	11	0 - 1
7	filed wil Hygien ther th		9		Nursir	19 ASSIS	me (First, Middle, Ma	Meal	cal
Maryland	2 should be filed within 72 hours aft and Mental Hygiens. Is marked other than "natural", or aumatic svent, the Medical Exert	Be	17 Father's Name (First, Middle, Last)	n C		Fa t	- Pine	Rigo	in
17	should and Men a marke umatic	_T	19a. Informant's Name/Relationship (Ty	pe, Prin	19b. Mailing Addre	ss (Street and Number or R	Pural Route Number, C	ity or Town, State, 2	ip Code)
	and 2 salth ar		Mr. Oscar Hi	Ilmon	1613 E	utaw Pl	ace #AL	Baltol	Md. 21217
ore,	es 1 an of Heal f Item 2 ir other		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ R		Place of Disposition (N cemetery, crematory of		- /	c. Location - City or	Town, State
Ë	Pagiment ment tant: i		*4 □Donation 5 □Other (Specify)	a IV	It. Lion) 11/2	3/2004 L	ansdou	une, Ma.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Items 23e or 28e-f show any injury or other traumatic svent, the Medical Examination and page.		21. Signature of Funeral Service License	"4 W.	Josep	and Address of Facility	Funegal	Home,	21211
			23a. Party. Enter the dispase, or compli	ications that caused the dea	th. Do not enter the ma	ode of dying, such as cardia	c or respiratory arrest	Fo, Ma.	Approximate
	Physician		shock or heart failure. List only or Immediate Cause (Final	ne cause on each line.		م مانیم			Interval Between Onset and Death
	/Medical	į.	disease or condition resulting in death)	Due to (or as a conse	quence f):	ery diseas) W		
4.	Examiner	_	Sequentially fist conditions,	Due to (or as a conse	mellity	5			
	pet usit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence oi):				
Ć,	execun n and ial-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a conse	quence of):				
094	death certificate be executed e attending physicien and id for use as the burial-transit	Icai	C.	d					
89)	artifica ing ph e as th	Med	IF FEMALE:	0 "					
Вох	attend for us	lan/	in the past 12 months?	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of	al death 3 Ectopic			23d. Date of defi Month	very Day Year
P.O.	0 0	Physician/M	1 ☐ Yes 2 🕱 No 9 ☐ Unknown	9 Unknown	osaii 3 Oillei (
	uires that the signed by th id be detache	by Pł	Part II. Other significant conditions con	ntributing to death but not re	sulting in the underlying	cause given in Part I.	23e. Did toba	cco use contribute to	
ırdş	w requires been sign should be	ted b	Hyperdension				1 🗆 Yes	2 □ No 3 Pr	obably 4 Unknown
Records,	aw is b	Completed					24a. Was an autopsy	prior to d	topsy findings available completion of cause of
<u>=</u>	Th ate pag	Con					performe 1 ☐ Yes 2	d? death? No 1 ☐ Yes	2 No
of Vital	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	lospitaf: 1 ☐ Inpatient 2 ☐	TER/Outpeticet 2016	Othor	eath (Check only one) Home 5 V Residence	o 6 □Other (See	ni4.1
o		\vdash	27. Magner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury at Work?	28d. De cribe how		any)
ion	Attending F r death. sctor: After by the funer	atio	1 Natural 5 Pending 2 Accident investigation	(MORIII, Day real)	Injury M	1 Yes 2 No			
Division	or Atta	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Pface of fnjury - At h building, etc. (Spec	nome, farm, street, factorify)	pry, office	28f. Location (Stree City or Town,	et and Number or Ru State)	ral Route Number,
۵	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Ce	29a, Certifier 1 Contifying Physics	sician: To the best of my kn	owledge death occurre	d at the time, date and place	e, and due to the cau-	se(s) and manner as	stated.
	24 hc 24 hc Fun letely	edical		ner: On the basis of examin and manner stated.					
	To th To th compl	Me	29b. Signature and title of certifier	,	2	9c. License number	290	l. Date signed (Monti	n, Day, Year)
	_		ien & Ree	nardio	y Mo	D53824	4 18)-Z5-	2004
	(A)		30. Name and address of person who co				7	0 713	,
	Sta	to	31. Date filed (Month, Day, Year)	32. Registrar's Sign	1476 Paul	Hoightshe	Ballo, 1	vo ZiZi)
1	Sta Registi			2001 hener	me la	local			

State of Maryland / Department of Health and Mental Hygiene For State Registra Reg. N.2 0 0 4 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 28,2004 **Physician** Appel 12:48A M F. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Apt103 Rosedale Baltimore 243 Attenborough Dr If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 8. Date of Birth (Month, Day, Year) 3/15/1914 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 90 212-05-9898 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County rthan "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2X No Baltimore Rosedale MD Director 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number 243 Attenborough Drive Apt103 21237 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Almed Porces? 1 XIYes 2 ☐ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White δ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) other than Life Insurance Agent Insurance permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 is marked othe any injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Frank Appel Francis Fischer 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vernon Adams/Grandson 23 Fuller Ave Baltimore MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Stanislaus Cemi 10/30/04 Dundalk MD 22. Name and Address of Facility Cvach/Rosedale Funeral Home 21. Signature of Funeral Service License 1211 Chesaco Ave Balto MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 45 /Medical to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed that initiated events burial-tran attending physician and resulting in death) Last Completed by Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year for Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No be detached Division of Vital Records, P.O. 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 □Unknown 1 🗌 Yes been 24b Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has page 2 certificate 1 Yes 2 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) funeral director Hospital: Other: 4 | Nursing Home 5 esidence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 🗌 Yes 2 No 1 Inpatient Certification: To this 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner Hospital or Attending 5 Pending investigation 1 atural 1 Yes 2 🗌 No within 24 hours after death. To tha Funaral Diractor: A 2 Accident the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 🗌 Homicide 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifier (Check only one) and manner stated To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier 29c. License number 0 person who completed cause 30. Name and address of Ž a va 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 9 2004 Registrar

State of Maryland / Department of Health and Mental Hygien 11

34407

		1 - Stete Registrar	•	Cei	tificate of	Death	R	eg. No.		04107
Phys	ician	1. Decedent's Name (First, Middle, La					2. Date of Deat Month	Day	Year	3. Time of Death
- /Me			Bovell				October	16,200	4	2:01am M
Exar	niner	4a. Facility Name (If not institution, given Washington Adven			4b. City, Town, o	r Location of Death Park		Montgo		
Funer Direct		5. Social Security Number 6. 5	_	ast birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day,	Year) 12, 1922	Coun	olace (State or Foreign ontry)
pu "		Usual Residence of Decedent	100 City	, Town or Lo	action					0d. Inside City Limits
e Maryla Ba-f shov	Director	NY	Kings		Bro	oklyn				XXYes 2 No
th with th	ai Dire	10e. Street and Number 280-E 57th Street			10f. Zip Code 11233		1	0g. Citizen of W USA	hat Coun	itry?
Defitilition (e.) Intally falling Z.I.Z.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Phyglene. Importent: If item 27 is marked other then "neturel", or items 23e or 28a-f show any injury or other treumatic event, In-Medical Evantment Les notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ⚠ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Was Decedent of H f Yes, specify Cuba I ☐ Yes 2500 No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- pecify Yes or No- pecify Yes	Black	- Americ k, White, Blac	
72 ho	eted	15. Decedent's E	ducation ade completed)	16a. Deced	lent's Usual Occup	nation during most of work d)	king	16b. Kind of Bu	siness/Inc	dustry
within then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	00 NOT use retired Dietician				Hospi	ital
filled v Hygie other i	ပိ	17. Father's Name (First, Middle, Last				18. Mother's Nam	e (First, Middle, M	Aaiden Sumame		
Iditalia lid be fill lental H rked out	o.	William B	rveghems			Jæep	hine Law	erence		
i, Malylo and 2 should ealth and Men n 27 is marke	-	19a. Informant's Name/Relationship (Dorreen Rodiney / Day				and Number or Rui Street, Henc		City or Town, S	State, Zip	Code)
Pages 1 and the control of Heisen and 15 item		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 2 4 □ Donation 5 □ Other (Speci	Removal from State	metery, cren	sition (Name of natory or other place Cemetery (october 23,	100	20c. Location - (,	
Dallillor permit. Pages Department of Importent: If it any injury or or	once.	21. Signature of Funeral Service Lice	··	22	Name and Addre	ss of Facility Stevens	s Funera	1 Home	Inc.	10-
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	polications that caused the death.	Do not ente	L501 East or the mode of dyin	Fort Ave	e Baltime or respiratory arre	ore MD :	21230	Approximate
Physicia /Medic Examin	al.	snock, or neart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. SEPTIC Due to (or as a consequence of the conse	Sho	ick				-	Interval Between Onset and Death
D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	ence of):		M.			\pm	
ecute and I-trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c. DIABE		MELLI	11 42			_	
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tificate g phy as the	Medical		U							
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	BeC	25. Was case referred to medical examiner?				26. Place of Deat	h_(Check only one			
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ding Phys After this funeral di	ion:	27. Manner of Death 1 Anatural 5 Pending	(Month, Day Year)	28b. Time of Injury	28c, Injun Worl		28d. Describe ho	w injury occurre	d	
To the Hospitel or Attending Physicien: within 24 hours after death within 25 hours after death. To the Funeral Director. After this certifics completely filled in by the funeral director.	Certification:	2 Accident investigatio 3 Suicide 6 Could not be 4 Homicide determined	B 20a Blace of Injury At hos	ne, farm, stre		163 2 110	28f. Location (Str City or Town	eet and Numbe , State)	r or Rural	Route Number,
To the Hospitel or At within 24 hours after d To the Funeral Direct completely filled in by	edical C	29a. Certifier 1 Certifying Pl (Check only one) 2 Medicel Example	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to							ated. the cause(s)
To the within To the	Me	29b. Signature and title of certifier			29c. License	e number	29	d. Date signed	(Month, E	Day, Year)
		> stuu	171e		D46	998	C	ctobe	R l	6,2004
30		30. Name and address of person who	completed cause of death (Item 2	341.	S HAM	ILTONS	T HYAT	TSVILLE	Mr	6,2004
	State	31. Date filed (100 2 9 200	3. Registrar's Signatu	Ire J	Look!	,	,			

Registrar

Amend item#3, perff, C837, 11/23/04 11

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 2004 Kathryn Irene Barker October 25, 8:30 a /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Pickersgill Towson Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 312 03 8076 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Min. 1 □ M 20 F Months Days Hours 91 Yrs. Oct 22, 1913 Oklahoma Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a, State 10h County r then "natural", or itema 23s or 28e-f show the Medical Examples must be notified at 1 Yes 2 No Completed by Funeral Director MD Baltimore Towson 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 615 Chestnut Avenue 21204 United States filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 € No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1, Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 6b. Kind of Business/Industry Own Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Pages 1 and 2 should be filed vitnent of Health and Mental Hygie tent: if item 27 is marked other toury or other traumetic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Columbus Clyde Swem Cecelia Elizabeth Neary ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4307 Conifer Court, Glen Arm, MD 21057 Susan Killian/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Oct 27 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Department of Importent: if any injury or once. 2004 Beltsville, MD Chesapeake Crematory 22. Name and Address of Facility
Cremation and Funeral Alternatives 21. Signature of Funeral Service Licensee 200986 8717 Green Pastures Drive Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) rib **Physician** + He /Medical Due to (or as a consequence of): Examiner Sevel Steeper osis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury peroved Due to (or as a correquence of): Examine ysician and e burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Be Completed by Physician/Medical the t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) signed by the a d be detached to 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. obstructive Lungdisease 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an Abdomund Acrtic Aneuritan Yos pheral VASCULAR di sease -2 No of Vital or Attending Physician: 2. Was ca e referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 🗷 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) ဥ 1 X Yes 2 □ No this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: got up from chair; Lost Balance and fell unto Coffee table in her a setment Division Injury 1 Natural 5 Pending 6:30 PM 1 🔲 Yes 2 No death. October 19 2004 investigation 2 Accident within 24 hours after deal To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 615 Chestnut AUE, Towson, Mary Litud Pickersgill Retvenut Community Approximent, o the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier October 25, 2008 125205 , ms 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balts. Ind 21204 N. Chorles GBMC 6701 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

OCT 2 9 2004

		_	For State Registrar	State of Mary		epartment of F Certificate of		Reg	ene	34409
	Physici /Medio Examir	al	1. Decedent's Name (First, Middle, Last) Thomas, A 4a. Facility Name (If not institution, give s	Bures treet and number)	Jr.	4b. City, Town, o	r Location of Death	2. Date of Death Month	Day Year 7 2004 4c. County of Death	3. Time of Death 7=04a
	Funeral	er	Mercy Hospital 5. Social Security Number 6. Sex		yrs. last birthe	Months Days	ACVE If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,)	(ear) 9. Birthr Cour 3.1920 MD.	e (if y place (State or Foreign ntry)
	Director Model	_	Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town	r Location dalk		August 2		I Od. Inside City Limit
	ith with the Marylar 23e or 28e-f show	i Directo	MD. Baltimor 10e. Street and Number 3118 Wallford Dri			10f. Zip Code 212	22	100	g. Citizen of What Cour USA	
980	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortent: if Item 27 is marked other then "naturel", or Items 23e or 28e-f show injury or other traumatic event, the Medical Evaluation and the invilled at injury or each other traumatic event.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates:	in U.S.	13. Was Decedent of Hif Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Wh	
21215-0036	within 72 ho iene. • then "natur ine Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 7 years	cation completed) College (1-4or 5+)	(6	ecedent's Usual Occup Give kind of work done fe. DO NOT use retired Milk Drive	during most of work d)	ing 16	Sb. Kind of Business/In Grocery	dustry
Maryland 2	should be filed withir ad Mental Hygiene. marked other then matic event, I to Ma	To Be Co	17. Father's Name (First, Middle, Last)	r.				e (First, Middle, Ma t Bures	aiden Sumame)	
	1 and 2 sho Health and I tem 27 is ma		19a. Informant's Name/Relationship (Type Marie Bures 20a. Method of Disposition	wife	311	8 Wallford	Drive Ap	t C., Dur	City or Town, State, Zipndalk, Md. Oc. Location - City or To	21222
Baltimore	permit. Pages 1 and Department of Health Importent: If Item 27 any injury or other tr once.		1X Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. Signeture of Fungral Service License	emoval from State	cemetery,	erematory or other place eart of Jesus	Cem. 30, 2	ober 2004 D	undalk,Md.	
Ä	permi Depa Impo any is		23a. Part1. Enter the disease, or compli	onnell	ay Do so	7110 Sol1	ers Point	Road, Di	ındalk,P.A. ındalk,Md.	21222
	Physician /Medical Examiner		shock, or heart failure." List only or Immediate Cause (Final disease or condition resulting in death)	Dub to (or as a co	GI	hleed	ncer		**	Interval Between Onset and Death
68760,	ate be executed thy sician and the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	nsequence of	:				
.O. Box 68	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pi 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death	3 □Ectopic pregnancy 5 □ Other (specify) □	,		23d. Date of delive Month	ery Day Year
<u>α</u>	iaw requires that the dias been signed by the 2 should be detached	by	Part II. Other significant conditions con	tributing to death but no	ot resulting in t	e underlying cause giv	en in Part I.	23e. Did toba 1 □ Yes	cco use contribute to the	
I Records,	The ate had page	Completed	anemia	P	055161.	e pheun	neniq	24a. Was an autopsy performe	24b. Were auto prior to co death? 1 \(\text{Yes}	psy findings available mpletion of cause of
Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	ospital:	2 ☐ ER/Outp	atient 3 DOA Oth	05	h (Check only one)	ce 6 ☐Other (Specif	iv)
of		-	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Yea		ne of 28c. Injur	y at k?	28d. Describe how		,,
Division	after death. Director: After	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, fam pecify)	M 1	Yes 2 □No	28f. Location (Stre City or Town,	et and Number or Rura State)	I Route Number,
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical		ician: To the best of moter: On the basis of exal and manner stated.		or investigation, in my o	pinion, death occur	red at the time, date	e and place, and due to	the cause(s)
	To t withi To t com	M	29b. Signature and title of certifier		40	29c. Licens	-1		d. Date signed (Month, 11/27/20 4 Hallian,	. /
	2		30. Name and address of person who co	mpleted cause of death	(Item 23a) (T	pe, Print)	o St. Pa	ul's Place	· halten,	M

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrar's Signature

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ı	Physici	an	Decedent's Name (First, Middle, Last)	T	1 1		2	. Date of Death Month	Day Year	3. Time of Death
	/Medic Examir	al	Gertrude H 4a. Facility Name (If not institution, give si		dard	4b. City, Town, or Loca	ation of Death	october	4c. County of Deat	4 9:00 PM
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ļ	Funeral Director				n yrs. last birthday) 31 Yrs.		Under 24 Hrs. 8 ours Min. M	Date of Birth (Month, Day, Ye arch 19,	9. Birti 2923 Ma	nplace (State or Foreign untry) assachusetts
	Maryland -f ehow fied at	tor	Usual Residence of Decedent 10a. State 10b. County Charles		oc. City, Town or Lo Waldorf	cation				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	or 289	Oirec	10e. Street and Number			10f, Zip Code		10g.	Citizen of What Co	untry?
	s 23a	rai	5319 Doris Drive			20601			USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f ehow any Injury or othar traumatic evant, 11. Medical Examinating the notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	 Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 	11	Vas Decedent of Hispan Yes, specify Cuban, Mo ☐ Yes 2 X No Sp	nic Origin? (Specit exican, Puerto Ric pecify:	iy Yes or No- can, etc.)	14. Race - Ame Black, White Specify:	
Maryland 21215-0036	72 hou	eted	15. Decedent's Educ (Specify only highest grade	ation	16a. Deced	ent's Usual Occupation	a most of working	16b	. Kind of Business/	
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0	filed v Hygie other t		17. Father's Name (First, Middle, Last)				Mother's Name (F			TILLI
/lan	uld be Mental Irked o	To Be	Louis Renaud				Yvonne D		,	
dar y	2 sho and h Is me	0. 7	19a. Informant's Name/Relationship (Typ			g Address (Street and N				ip Code)
	1 and Health am 27		Rene J.A. Bedard 20a. Method of Disposition	(Son)		Doris Driv sition (Name of patory or other place)	ve Waldo		U601 Location - City or 1	Own State
Baltimore,	t. Pages rtment of I rtant: If its njury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	Silloval IIOIII State	St. Josep	h Cemetery	10-30	-04 C	helmsford	
Ba	Depa Impo any Is		21. Signatur of Funeral Service Chanse	Debo		Name and Address of McKenna-Oue 327 Hildre	th Stree	t Lowell	Home , MA 018	50
	Physician /Medical Examiner	6	23a. Part 1. Enter the disease, or complic shoot, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)	e cause on each line.	no Ves	er the mode of dying, suc				Approximate Interval Between Onset and Death
00	ificate be executed g physician and as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co						
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ds, P.	uires that (signed b) Id be deta		Part II. Other significant conditions conti		-	, -	Part I.	23e. Did tobacc		the cause of death?
Records,	2 2	Completed	Hypertens	Artery	Disease	2		24a. Was an autopsy performed?	prior to co	opsy findings available impletion of cause of
Viita		BeC	25. Was case referred to medical examiner?			26.	Place of Death (C	1 Yes 2 7	No 1 ☐ Yes	ZLY NO
	> 20 D	ပ	1 ☐ Yes 2 No Ho 27. Magner of Death	spital:	2 ER/Outpatient				6 ☐Other (Speci	fy)
O	ding h. After fune	tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	ear) 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes		. Describe how in	jury occurred	
Division of	= 00	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (S	At home, farm, stre Specify)			Location (Street City or Town, Sta	and Number or Rur ite)	al Route Number,
	To tha Hospital or At within 24 hours after of To the Funaral Dirac completely filled in by	Medical C	29a. Certifier 1 Certifying Physic (Check only one)	cian: To the best of m er: On the basis of exa and manner stated	imination and/or invi	occurred at the time, da estigation, in my opinion	ite and place, and n, death occurred a	due to the cause at the time, date a	(s) and manner as s nd place, and due t	stated. o the cause(s)
	To th within To th	Me	29b. Signature and title of certifier	. /		29c. License num	ber	29d. D	Date signed (Month,	Day, Year)
)			I Souther V	dagan	MD	051	051	Do	tuber 2	7, 2004
	N		30. Name and address of person who com And wey Salaz		(Item 23a) (Type, F 2 1 5 / u	cart Lane	e, cliv	uton, N	lary land	.20735
	Sta Registr		31. Date filed (Month, Day, Year) QCT 2 9 : 2004	32. Registrar's	Signature	Sports			7	7, 2004 ,20735

State of Maryland / Department of Health and Mental Hygiene 0 14 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 12:45 p M October 2004 Janet Hopkins Bauer /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) Sept. 30,1930 If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2 X F 74 Director 217-26-6865 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Exertines must be redified at 1 ☐ Yes 2 ▼ No Director MD Anne Arundel Gambrills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 2607 Chapel Lake Drive 21054 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. 1 ∐Yes 2√XNo If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: White þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Clarence G. Hopkins Harriet Aldridge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is rr any injury or othar traum once. G. Jackson Bauer (Husband) 2607 Chapel Lake Drive, Gambrills, MD 21054 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 10/28/2004 * 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Baltimore, MD 21. Signature of Sunaral Service Licensee 22. Name and Address of Facility
Hardesty Funeral Home P.A Oalset 12 Ridgely Avenue, Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Plectiomechaniel Priysician Mountres disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner hemorrhance Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ed by the attending physician and detached for use as the burial-transit death certificate be executed muld antic Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 2 should be ficiency renerel 1 Yes 2 No 3 Probably 4 Unknown Completed peen : 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has t irector, page 2 s autopsy performe Yes 2 No Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 図Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide cai 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sule 520 Annapolis 2002 Medical martin tarkwas 31. Date filed (Month, Day, 32. Registrar's Signature State Registra

				For					Health and	•	giene o	ne.	01110
				1 - For State Registrar				tificate of			Reg. No.	4	34412
		Physici	an	Decedent's Name (First, Middle,	Last)					2. Date of De Month	Day	Year	3. Time of Death
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				Upper Chesapea 5. Social Security Number 6	ke . Sex	7. Age (In yrs.)	last birthday)	Be	1 Air If Under 24 Hrs.	8. Date of Bi		rfor	
0,		Funeral Director		218-28-7297	1 X M 2□ F	72	Yrs.	Months Days		(Month, D	4, 1932		lace (State or Foreign stry) arvland
5		and *		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or La	cation				1	0d. Inside City Limits
15,		Maryli f sho	ţō		ford			est Hill					1 ☐ Yes 2X No
		th the or 288 e notif	Director	10e. Street and Number	1010		FUL	10f. Zip Code			10g. Citizen of W	hat Cour	itry?
+		death with the Maryland ms 23a or 28a-f show		1611 Kreitler V				210				. A.	
10	10	fter de ritems in er n	Funerai	11. Marital Status 1 ☐ Never Married 2 ☑ Marrie	Armed F		S. 13. 1	Was Decedent of H f Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No to Rican, etc.)	0- 14. Race Black	- Americ , White,	an Indian, etc.
2	5-0036	ours a	by	3 Widowed 4 Divorced	If Yes, G Year or I	2 To No ive X Dates:		1 ☐ Yes 2 💢 No	Specify:		Specify:	W	hite
125/04	15-0	parmit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natural", or items 23s or 28s-f show may rightly or other traumatic avant, the Mudical Examines from the multifulations. Once.	Completed	15. Decedent's (Specify only highest)	(Give	lent's Usual Occup kind of work done OO NOT use retire	during most of wor	rking	16b. Kind of Bus	iness/Ind	dustry
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~	Pu	e filec at Hyg at other	Bec	17. Father's Name (First, Middle, La	ist)			I GON DIA		me (First, Middle	, Maiden Sumame		1,01) 00.
	Maryland	Meni Meni Marke Marke	2	Mordeica Bucki	100					Dillman			
	Mai	od 2 st lth and 27 ls r traun		19a. Informant's Name/Relationshi Hazel Loretta Bucking		۵)			and Number or Ru		90.5500		
	Jre,	of Heal		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of natory or other place	ce)	Date PO	20c. Location - C		
36	Baltimore	ment ment tant: It in o		1 ☐ Burial 2 ☑ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spe		Bay	vview (Crematory	10/3	0/2004	Baltimo	re, l	Maryland
	Ball	parmit Depart Impor Impor any in		21. Signature of Funeral Service Lie	censee		22	. Name and Addre	ess of Facility Sch	nimunek	Funeral	Home	of Bel Air
5				23a. Part1. Enter the disease, or or	omplications that	caused the death	. Do not ente	1 c., 610 or the m <i>o</i> de <i>o</i> f dyir	W. Macph	ail Rd.	Bel Air,	_Md.	21014 Approximate Interval Between
0		Pnysician		shock, or heart failure. List or Immediate Cause (Final disease or condition	nly one cause on	each line.	70	7770					Interval Between Onset and Death
5		/Medical Examiner		resulting in death)	aDue to	(or as a consequ	ence of):	7 7	1 1 1				
		Examiner	ē	Sequentially list conditions,	b	(or as a consequ	ience of):	X / CO	girano	W CEX			
am	4	executed n and ial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c								
ha	2094	sician and burial-transit		resulting in death) Last	Due to	(or as a consequ	ience of):						
90	687		dicai		d								
11	Box (n certifica anding ph use as th	In/Me	IF FEMALE: 23b. Was decedent pregnant		ıtcome of pregnai birth 2 ∏ Fetal		IC.			23d. Date	of delive	ry
Ck	.O. B	es that the death certificat igned by the attending phy be detached for use as th	Physician/Medi	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		nant at time of de		Ectopic pregnancy Other (specify)	y 		Mont	h	Day Year
Z	a	The law requires that the ste has been signed by the bage 2 should be detache	by Ph	Part II. Other significant condition	s contributing to	death but not resu	liting in the ur	nderlying cause giv	en in Part I.	23e. Did t	obacco use contrit	oute to th	e cause of death?
	ords	w requires tha been signed should be dei		Chronic (16574	JALLON	Phylon	mary 9)	126008		Yes 2□No 3	□ Proba	ably 4 Unknown
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~	al	n: The ficate nr, pag		1) yter 10	2 godo)	c He	Part	DISEM		1 Yes	2 No 1	ath?] Yes	2□ No
(0)	Vital	Physician: this certifical	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	Inpatient 2 □ t	ER/Outpatien	3 DOA Oth	26. Place of Dea		one) dence 6 ⊡Other	/Specific)
90	n of	ng Ph fter thi	D: T	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date		28b. Time of Injury	28c. Injur Wor	v at		how injury occurred		/
7	Division	tandii Jeath. tor: A the fu	ertification:	2 Accident investiga 3 Suicide 6 Could no	. ho				Yes 2 □ No	20/ 1			
8	Div	after after I Dirac	ertif	4 Homicide determin	ed 288. Plac build	e of Injury - At ho ling, etc. (Specify	me, iarm, stre	eet, factory, office		City or To	Street and Number wn, State)	or Hurai	Houre Number,
		To the Hospital or Attanding Physician: The lav within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier (Check only one) Certifying 2 Medical Ex	aminer: On the b	e best of my know pasis of examinat oner stated.	wledge, death ion and/or inv	occurred at the tir	me, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and mand date and place, an	ner as sta	ated. the cause(s)
		To th within To th compl	Me	29b. Signature and title of certifier	100		· M	29c. Licens	se number	-11	29d. Date signed	Month, [Day, Year)
		1		· WILLIAM	11.W.	mos	(XII)	Do)C + 000	27	N(10 PX	12	6,2004
		V		30. Name and address of person w	no completed cau	se of death (Item	23a) (Type, 1	Bel dir	Roal.	T-a/15	ton W	1/2	1047
	175	Sta		31. Date filed (Month, Day, Year)		Registrar's Signat	ure	,				*	
		Registi	ar	اللالم الم	4004	Denne	- 4	Som	1				

State of Maryland / Department of Health and Mental Hygien [] [] For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 23 **Physician** Aliene V. Butler OUBBER 10.05A M 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner NORTH ARUNIDEL ANNE ARUNDEL HISPITAL GLEN BURNIE If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🂢 F 219-12-9704 82 Director Apr 25, 1922 Maryland Usual Residence of Decedent 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits Itams 23a or 28a-f ehow other traumatic event, the Medical Examiner must be notified at MD Anne Arundel Glen Burnie 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 7355 E. Furnance Branch Road 21061 Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If item 27 ie marked other then "naturel", or flams 23. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: white 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) factory worker 17. Father's Name (First, Middle, Last) unk 18. Mother's Neme (First, Middle, Maiden Sumame) Be unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Breeding/friend 6650 Whitmore Court Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, Stete permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🕅 Other (Specify) in state Signature of Europe Rona I d 22. Name and Address of Facility Wade, Dixector State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 acel 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition UROSEPSIS **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner HPART BNIBBING Sa uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner burial-transit The law requires that the death certificate be executed ATHEROSCIEROTIC CARDIOVASCULAZ Due to (or as a consequence of): P.O. Box 68760, physician use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Year Month Dav 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 🗌 Yes 2 🗆 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? 1 Yes 2 No To the Hospitel or Attending Physicien: filled in by the funeral director, 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Watural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a
To the Funerel C
completely filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and tipe of certifier 29c. License number D 45149 Mis BETOBER 23 2004 30 Name and address of person who completed the complete of th completed cause of death (Item 23a) (Type, Print) Chen BURNE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 2 9 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Sadie Edwina Bennett October 22, 2004 9:15 PMM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Havre de Grace

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, Sept 5, 19 Harford 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1□M 2♥F 212-70-7458 80 Yrs Director England Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itams 23a or 28a-f show the Medical Examinat must be notified at MD Harford Havre de Grace 1 ☐ Yes 2√ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 415 S. Market Street 21078 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white þ 3 TrWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 0 housewife own home 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 Is marked oth any jury or other traumatic event 900g. 18. Mother's Name (First, Middle, Maiden Surname) Sidney Joseph Edmunds Edith Emily Benwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leeanna Rossman/daughter 155 Bloomsbury Avenue Havre de Grace, MD 210 e of Disposition (Name of Date 20c. Location - City or Town, State 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State *4 Donation 5 ☐ Other (Specify) 27 Signeture of Euneral Service Licensee Ronald S. Wade, 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 23a. Rant1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) etastatic **Physician** wk5 /Medical Due to (or as a consequence of): Examiner -arcinoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ alnutaliun 1 Yes 2 No 3 Probably 4 Unknown Completed peen; 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 20000 has certificate 1 ☐ Yes To the Hospital or Attanding Physician: within 24 hours after death.

To tha Funaral Diractor: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 X Natural 2 ☐ Accident 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification 5 Pending investigation 1 Tes 2 No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)
OCT 2 9 2004

unam

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kamprudy Allbani MD II oc Rev 1106 Revolution St. Harre De Graze MD 21078 32. Registrar's Signature

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			For State Registrar	State of Marylar		rtment of F			ien () () eg. No.) 4	34415
	Physici	an	1. Decedent's Name (First, Middle, Last					2. Date of Dear Month	Day	Year	3. Time of Death
	/Media	cal	Noreen Adele Brid 4a. Facility Name (If not institution, give		l l	4h City Town o	or Location of Deat	October	4c. County		9:45 A M
	Examir	ıer	2238 Tollgate Ci			Bel Air		11		rford	
	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs.	last birthday)	If Under 1 Year Months Days				,	place (State or Foreign
	Director		125-40-8583	^{3 M 2} 2 56	Yrs.	Months Days	Hours Min.	oct. 10	, 1948	New	York
	and wo		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Lo	cation					10d. Inside City Limits
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336	irs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes ② No If Yes, Give Year or Dates:	1	☐ Yes 2 📆 No	Specify:		Specif	y: Wh	ite
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2	lled w Hygier ther th		17. Father's Name (First, Middle, Last)	3	Reg:	istered 1			Health		
anc	d be fi	o Be	Edward Charles	Brideson			Mae Ad	ne (First, Middle, M Pele Tie	raiden Suman Mev	18)	
<u></u>	should nd Me mark mark	ပ	19a. Informant's Name/Relationship (7)		19b. Mailin	Address (Street		rai Route Number		State. Zir.	Code)
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ore,	ges 1 and t of Health if item 27 or other tr		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ F	20b. F	Place of Dispos	sition (Name of atory or other place		Date	20c. Location -	City or To	own, Slate
<u> </u>	Pag ment ant: i		'4 □Donation 5 □ Other (Specify)	Hi	lltop s	Service (Corp. 10-	-30-04	Towson,	, Mar	yland
Baltimore,	permit. Pages 1 Department of F important: if ite any injury or ot		21. Signature of Funeral Service Licens	99	Mc	Name and Addre	ineral Ho	me, P.A.			
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8760,	be executed sician and burial-transit			Due to (or as a conseq	uence or):						
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o	ding Phy h. After thi funeral c	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur	v at	28d. Describe ho			<u>'</u>
ior	Attendin death. ctor: Aff y the fur	atio	1 Natural 5 Pending investigation	(Worth, Day Your)	injury		Yes 2 □No				
Division of Vital Records,	i or Attencater death Director:	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stre	et, factory, office		28f. Location (Str City or Town		er or Rura	l Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	al Ce	29a. Certifier 1 Certifying Phy	pinion. To the heat of my kno	uuladaa daash						
	24 hos Fun	dic	(Check only 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	tion and/or inv	estigation, in my o	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	use(s) and ma te and place, a	nner as stand due to	ated. the cause(s)
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Me	29b. Signature and title of certifier			29c. Licens	e number	29	d. Date signed	i (Month, L	Day, Year)
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			31. Date filed (Month, Day, Year)	32. Registrar's Signa		esho!	Bel	Dir W	P		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 4 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** 27, October, 2004 15:40 Gloria Marie Carter /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Memorial Gardens Havre de Grace Harford If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🗓 F 220-20-9386 Director Nov. 4, 1924 Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County in then "naturel", or items 23e or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1413 South Fountain Green Road 21015 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: ģ 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 8 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Barney Stanford Coulson Lucy Texas Harris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 50 Pine Cone Drive, North East, MD 21901 Geneva M. Johnson / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Importent: If ite
any injury or ott 1X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gardens 10-30-04 Bol Air, Maryland 21. Signature of Funeral Service Licensee ²² Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on-cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 1000/2 MYOCARDIAG INFAILCTION /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ OBSTRUC 1 Yes 2 ₽NO 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No certificate 1 Yes 2 ₩ Atter this certitic funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☑Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Ho 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) δ 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier al la lanh wo PIL 014036 october 28, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RUNE P. de 105 CHIVTOS 2535 CHURCHUILL, KAPRIJAND 200

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

OCT 2 9 2004

Larten, Gloria

32. Registrar's Signature

		end Item			Ce	rtificat	e of L	Death	1			.00	+ 34	417
Physiciar	P.R. I		DAVIS							2. Date of D OCTOD		200	3. Tirr	e of Death 47 Pu
/Medica Examine	4 - 5 10 14			ber)		4b. City,	Town, or	Location of	of Death		4c.	County of D		
		okins Hos					ltim					1/A		
Funeral Director	5. Social Security No. 213 86 Usual Residence of	1090 4	XM 2□F 7	. Age (In yrs.	last birthday) Yrs.	Months	1 Year Days	if Under Hours	Min.	8. Date of Bi (Month, D MAY 5	ay, Ye <i>ar)</i>		Birthplace (Sta Country) ARYLAN	_
yland	10a. State	10b. County		10c. Cit	ty, Town or Lo	cation							10d. Insid	e City Limits
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with ti	10e. Street and Nun		ר שווואי	PT. #	2	10f. Zip	Code 1207	7				zen of What		
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or ita	1 Never Marrie	ed 2 Married	Armed Forc 1 ∐Yes 2 If Yes, Give	DINO		tYes,speo 1 ☐ Yes		n, Mexican Specify:	i, Puerto I	Rican, etc.)	1		Vhite, etc.	
hours a tural; o	3 Widowed	4 Divorced 15. Decedent's Ed	Year or Date	es:	16a. Dece						-	Specify:B		
Maryland 21215-0036 d 2 should be filed within 72 hours after th and Mental Hygiene. 77 Is marked other than "natural", or its traumatic evant, the Medical Exam. To Be Completed by E.	(Speci	ify only highest gra		for 5+1	UNEMP	kind of wo	rk done d	luring mos	t of workin	ng	16D. KI	nd of Busine	ess/industry	
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ire, Maryland Z IZ IS-0030 s 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic evant, its Medical Exam actional be controlled at	17. Father's Name ((First, Middle TH HA				
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and 2 and 2 and 2 and 2 artrau	ELIZABET			HER)									MORE, M	D 212
Saltimore, IM bernit. Pages 1 and 2 bepartment of Health mportant: if item 27 i iny injury or other tre	20a. Method of Disp 1 X Burial 2 [4 Donation	osition Cremation 3 5 Other (Specify	Removal from St	ate 20b. F	Place of Dispo	sition (Nan	ne of		D	ate	20c Lo	cation - City	or Town, State	2
Baltimory permit. Pages: Department of P important: if ite any injury or of	21. Signature of Fu	neral Service Line	Bir	GWYNI	29	EWIS	S Addres	s of GWY	NN I	FUNERA S AVEI	AL H		21215- CO.,MD	
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/Medical Examiner	resulting in death)			r as a conseq										
	Sequentially list cor if any, leading to im cause. Enter Under	nditions, mediate	b. Due to (or	r as a conseq	uence of):								-	-
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cate be executed by sician and the burial-transit	resulting in death) L	ast	Due to (or	r as a conseq	uence of):									
			d											
The law requires that the death certific the law requires that the death certific ate has been signed by the attending page 2 should be detached for use as completed by Dhysician Magnetical by Dhysician Magnetical and the page 1.	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outco	ome of pregna							2	3d. Date of	delivery	
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that the de ed by the detached	9 Unknown	cont conditions			udain n in ab					00 - Did				
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The law requires the cate has been signed page 2 should be completed by										24a. Was			autopsy findin	
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VICAL siclan: T certificat rector, pa		<u> -</u>						26. Place	of Death	(Check only			es 2 No	
Attending Physician: r death. sactor: After this certificity the funeral director. fifeation: To Re C	1 XYes 2□	1	Hospital:		ER/Outpatien			4 🗆 1401		ie 5□Resi			ipecify)	
INTERIOR OF OF A STREET OF THE	27. Manner of Death	5 ☐ Pending investigation	28a. Date of 10-24	Day Year)	28b. Time of 2:30	21 - M	8c. Injury Work 1 🗀 Y		ula.	8d. Describe		occurred		
Attend r death actor: / by the f	2 Accident 3 Suicide 4 Homicide	6 Could not be determined	28e. Place of	f Injury - At ho	tound ome, farm, str	et, factory		- X -		unknow Bf. Location (Number or	Rural Boute N	umber,
tal or Attending P tal or Attending P rs after death. al Diractor: After ted in by the funera	4 Homicide		found	, etc. (Specify	V)				Ba	City or Too	vn, State) re。 N	1655 laryla	Rural Route N Darley nd	Ave.
To the Hospital or Attending Physician: The within 24 hours after death. To the Funaral Director: After this certificate his completely filled in by the funeral director, page		1□ Certifying Phy 2⊠ Medical Exam	vsician: To the be iner: On the bas and manne	is of examina	wledge, death tion and/or inv	occurred a restigation,	at the time in my opi	e, date and inion, deat	d place, ar	nd due to the	cause(s)	and manner	as stated	e(s)
To the Company of the	29b. Signature and	title of certifier	, 1,			29c	. License						onth, Day, Year	
	1 le	when I	1. K.	Su	0								2, 2004	
	30. Name and addre	ess of person who o	ompleted cause	eath (Item	23a) (Type, Penn	Stree	et, E	Balti	more,	Mary]	and	21201		
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DHMH 17 Rev 1/2001

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N			For State Registrar	State of	Maryland / D		tment of He ificate of E			iene 200!	+ 34418
	Physicia /Medio	an	1. Decedent's Name (First, Middle, John P. Delaney						2. Date of Dea Month October	Day Yea	3. Time of Death 2104 P M
	Examin		4a. Facility Name (If not institution, 12731 North Calv	*	•		4b. City, Town, or Baltimo	re		4c. County of De	
	Funeral Director		401-74-6480	5. Sex 7. XX M 2□ F	Age (In yrs. last birth		If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day 08/25/1	9. E 950	Birthplace (State or Foreign Country) KY
	ryland how		Usual Residence of Decedent 10a. State 10b. County	AT / 3	10c. City, Town	or Loca					10d. Inside City Limits
	ith the Ma or 28a-1 s	Director	MD 10e. Street and Number 2731 Calvert St	N/A troot			Baltimo	21218	,	10g. Citizen of What USA	1 @Yes 2 No
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hyglene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, I're Madical Eventing Institute Incilliant	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Deced	es? IXINo	lt)	as Decedent of His Yes, specify Cubar	spanic Origin? (Sp	pecify Yes or No- Rican, etc.)		merican Indian, hite, etc. white
21215-0036	within 72 horane. sne. than natura	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		or 5+)	(Give kii life. DC	nt's Usual Occupa ind of work done d O NOT use retired) stem Anal	uring most of wor	-	16b. Kind of Busine Dept. of	ss/Industry Labor, Govt.
S	12 should be filed within "h and Mental Hygiene. 7 Is marked other than "Iraumatic event, Ira Mas	To Be Co	17. Father's Name (First, Middle, L. John Patrick	ast)				18. Mother's Nam	e (First, Middle, era Haye	Maiden Sumame) S	
Maryland	alth and M 27 Is mar traumat	-	19a. Informant's Name/Relationshi Anna Vera Dela				Address (Street a			r, City or Town, State e KY 402	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other tra <u>once</u> .		20a. Method of Disposition 1 Daurial 2 Cremation 4 Donation 5 Other (Spe		ate 20b. Place of cometer, Calva	v croma	tion (Name of atory or other place Cem. Octo	ber 25,	^{Date} 2004	20c. Location - City Louisvi	
Balt	permit. Departri Imports any Inji		21. Separature of Funeral Service L	1		150	01 East 1	. Steven: Fort Ave	nue, Bal	1 Home, I timore MD	nc. 21230
	Physician /Medical Examiner		23a. Part1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	_a. att	used the death. Do not tine.	tu		such as cardiac			Approximate Interval Between Onset and Death
8760,	icate be executed physician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	r as a consequence of						
.O. Box 68	death certiff e attending id for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live bin	ome of pregnancy th 2 Fetal death at at time of death		Ectopic pregnancy Other (specify)	1 11/1/11		23d. Date of Month	delivery Day Year
Δ.	w requires that the been signed by the should be detache	by	Part II. Other significant condition	ns contributing to dea	th but not resulting in	the unc	derlying cause give	en in Part I.			e to the cause of death? Probably 4 Unknown
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ion of Vital	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Diractor: After this certificate completely filled in by the funeral director, pag	ation; To Be	25. Was case referred to medical examiner? 1 (XY) es 2 \(\) No 27. Manner of Death 1 Natural 5 \(\) Pending investig:	28a. Date of (Month)	patient 2 ER/Ou Injury 28b. T Day Year) Ir	tpatient Fime of njury	28c. Injury Work	ar: 4 ☐ Nursing H			ipecify) At scene
Division	To the Hospital or Attent within 24 hours after death To the Funeral Diractor: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	and 286. Flace C	of Injury - At home, fa g, etc. <i>(Specify)</i>	rm, stree	et, factory, office		28f. Location (S City or Tow	itreet and Number or n, State)	Rural Route Number,
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	To the within 2 To the comple	Me	29b. Signature and title of certifier	.1 2.	/	,	29c. License		į.	29d. Date signed (M	
	h		30. Name and address of person v THEODORE HILL		of death (Item 23a) (October 1 Maryland	
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Re	gistrar's Signature	4	<i>f</i> .			-	

ORIGINAL

		_	For State Registrar		State o	of Marylan	d / Depa <i>Cer</i>	rtment of l tificate of	Health an Death	nd Mental Hy	Reg. No		34419
	nysicia		Decedent's Nam Robert	e (First, Middle	, Last)			Dovell		2. Date of D Month Octob		8, 2004°	3. Time of Death 3:25 P M
	Medic xamin	_	4a. Facility Name (, give street and nu			4b. City, Town,				: County of Dea	th
	neral		5. Social Security N	umber	6. Sex 1 X M 2 □ F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24	Min. (Month, D	irth Jay, Year)	9. Bir	thplace (State or Foreign puntry)
ъ	ector		213-36-6 Usual Residence o	f Decedent			65 Yrs.			November	19,1	938 MI	
Marylar	la Dei	or	10a. State	10b. County Balti	more	10c. Cit	y, Town or Lo Dund						10d. Inside City Limits 1 ☐ Yes 2 🛣 No
th with the 1	ust be notif	al Director	10e. Street and Nu 1905 Wal		enue			10f. Zip Code 21	1222		_	tizen of What Co JSA	L
I E I E I S-0000 filed within 72 hours after death with the Maryland Hygiene.	iteli s'i is markeo otret inan inatuali, unemis socio soci anom other treumatic event. I'm Medical Eraminar must be notifiad at	by Funeral	11. Marital Status 1 Never Marr 3 Widowed	_	Amned F	2 □ No ive	į.	Vas Decedent of f Yes, specify Cub □ Yes 2X No		n? (Specify Yes or N Puerto Rican, etc.)	0-	14. Race - Ame Black, White Specify: Wh	
72 hou	dical E			15. Decedent			16a. Deced	lent's Usual Occu kind of work done	pation during most d	of working	16b. K	ind of Business.	
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nd 2 should be filed within and Mental Hygiene.	ic event.	To Be C	17. Father's Name William		Last)					s Name (First, Middle aret Dove		Sumame)	
nd 2 shoulth and N	r treuma		19a. Informant's N			ife		-		or Rural Route Number Dundalk,			Zip Code)
permit. Pages 1 and 2 Department of Health a	ry or othe		20a. Method of Dis 1 Burial 2 4 Donation	Cremation	3 ☐Removal from	0	emeterv, cren	sition (Name of natory or other pla t of Mary		ovember 1, 2004		ocation - City or	
permit. Pages Department of	any inju		21. Signal of Fu			ne l li	1 22	Name and Addr	ess of Facility Funera	l Home Of	Duno	dalk.P.A	e de traca contror
*			23a. Part1. Enter t shock, or hea	the disea or art failure. list	complications that		. Do not ente	er the mode of dy	ing, such as ca	ardiac or respiratory	arrest,	·	Approximate Interval Between Onset and Death
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Exam	niner 3	_	Sequentially list co	onditions,	b	(or as a consequ				0			
	ransit	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events	5	C	(or as a consequ	derice ory.						
icate be executed	for use as the burial-transit	al Ex	resulting in death)	Last	Due to	(or as a consequ	uence of):						
artificate	e as the	Medical	IF FEMALE:		J								
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vicion: The law required to the law required t	N	Completed								24a. Wa auto perf 1 🗆 Yes		prior to death?	utopsy findings available completion of cause of 2 No
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To the Hospitel or Attending Phys within 24 hours after death.	in by the funeral	Certification;	2 Accident 3 Suicide 4 Homicide	investig 6	ot be 28e. Place	e of Injury - At ho ling, etc. <i>(Specif</i>)	ome, farm, stre	M 1]Yes 2□No	28f. Location	(Street an own, State	nd Number or Ru a)	ıral Route Number,
e Hospite 24 hours	completely filled in	edical C	29a. Certifier (Check only one)	Certifyin	Examiner: On the b	e best of my kno pasis of examina nner stated.	wledge, death tion and/or inv	occurred at the firestigation, in my	me, date and opinion, death	place, and due to the occurred at the time	cause(s)) and manner as d place, and due	stated. to the cause(s)
To the within	сошр	Me	29b. Signature and	title of certifier	00	lu 1	/	29c. Licen	se number	,	29d. Da	te signed (Monti	h, Day, Year)
	1		30. Name and add		who completed cau	se of death (Item		Print)	A R.	4314 BX	141	MARIE	21237
it R	Sta legistr	*	31. Date filed (Mor			Registrar's Signa	ing A	souls	101	JIY DX	V[(/ /	11010	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar AMEND FIEM #1,7,15&19a PER FIED 9837 11/05/04JE Date of Death

1. Decedent's Name (First, Middle, Last)

1. Decedent's Name (First, Middle, Last) Reg. No. 2 0 0 12 October 26, Delcostello Mannie Del Costello 2004 **Physician** 8:26AM /Medical 4a. Facility Name (If not institution, give street and number)
Gilchrist Hospice 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5/23/1915 5. Social Security Number Birthplace (State or Foreign Country) Funeral 214-10-6820 1 ☐ M 2X F Director MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28e-f show treumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2 No Director MD Baltimore White Marsh 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5302 Bangert Ave 21162 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2√2 No Specify: 2 Specify: White 3 XWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7: th and Mental Hygiene. 7 le marked other than *n Elementary/Secondary (0-12) **5** 12 College (1-4or 5+) Poly Seal Machinist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edward Phillips Helen Dize Philipp I's Name/Relationship (Type, Print)
Philip DelCostello/Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 and 2 bepartment of Health ar Importent: If item 27 le eny injury or other treu 5302 Bangert Ave White Marsh MD 21162 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 10/29/2004 Baltimore/MD ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cvach/Rosedale Funeral Home 1211 Chesaco Ave Baltimore MD21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician MOSTANISTA P Ne unavit Wreks /Medical Due to (or as a consequence of): Examiner Demensin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit cerebourseran differse Due to (or as a consequence of): attending physician for use as the burial IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Cther: 4 Nursing Home 5 Residence 6 ther (Specify) SPICE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 27. Manner of Death 28c. Injury at Work? 28b. Time of Division 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospitel within 24 hours e To the Funerel Completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) N 58303 October 26 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Agreed CHARLIES MO 6601 DOLTIMONE MOZIZOY N 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 2 9 2004 Registrar

State of Maryland / Department of Health and Mental Hydien 9 1 1.

			For State Registrar	State of Ma	ryland			nt of H te of L				gieni Reg. No		344	21
			Decedent's Name (First, Middle, L.	ast)							2. Date of De	ath Da	av Year	3. Time of	Death
	Physicia		Sadie	6	110	son					OCTUB		26,20	4 151	2 M
3	/Medic Examin		4a. Fecility Name (If not institution, gi				4b. City	, Town, or	Location	of Death		40	. County of Dea	ith	
	LAUIIIII	٠'	UNIVERSITY HOS	PITAL			BA	LTIMO	ORE				N/A		
	Funeral		Social Security Number 6.	Sex 7. Ag	(In yrs. la	ast birthday)		r 1 Year		24 Hrs.	8. Date of Bit (Month, Da	th Vear	9. Bi	thplace (State or ountry)	r Foreign
	Director		220-18-9124	1□M 2XF	77	Yrs.	Months	Days	Hours	Min.	2-13-			RYLAND	
-	D		Usual Residence of Decedent												
	nylan how		10a. State 10b. County			, Town or Lo								10d. Inside Cit	•
	a-f s	cto	MD. N/A		DA.	LTIMOR	LE							1,4,103	20140
	72 hours after death with the Maryland natural, or Items 23a or 28a-f show disal Examine must be notified at	Director	10e. Street and Number				10f. Z	p Code				10g. C	itizen of What C	ountry?	
	th wi	ai	1437 N. FULTON	AVE.				2121					USA		
	dea	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	S. 13.	Was Deci	edent of Hi	ispanic Oi	rigin? (Spe	cify Yes or No Rican, etc.))-	14. Race - Am Black, Wh		
9	or It		1 Never Married 2 Married	1 ☐ Yes 2 🔯 I	lo	1	1 🗆 Yes	V	Specify				Specify: B	LACK	
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7	should be ind Mental ind Mental is marked o	L _o				10h Mailie	- Add	a (Ctront	and Alumb				or Town, State,	Zin Codel	
Maryland	2 sh and Is n		19a. Informant's Name/Relationship MANNIE ELLISON		(חו		3							ND 21217	,
	ss 1 and 2 of Health I Item 27 I		20a. Method of Disposition	DR. (HODBIL		ace of Dispo							ocation - City o		
ō	Pages 1 nent of H int; if Ite		1 DBurial 2/1 Cremation 3		CE	emetery, crer	natory or	other plac	1	11-3	-2004		•		
Ë	tant:		'4 □Donation 5 ☑ Other (Spec	• •		RISON					TTDC			LS, MARY	LAND
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examener must be notified at ance.		21. Signature of Funeral Service Lice	PASSO JUNATHAL	י • תו									•	217
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			23a. Part Enter the disease, or conshoot, or heart failure. List only	y one cause on each li	ne.	i. Do not ent	er the mo	ide of dyin	g, such a	s cardiac c	respiratory a	mest,		Interval Bet	ween
5	Physician		Immediate Cause (Final disease or condition resulting in death)	a Pulmo	nary	AV	rus	Γ						1 hou	·V
	/Medical Examiner		resulting in death)	Due to (or as										C >	
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.11	∕o is	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	_	>								
Ví	and and -tran	хап	that initiated events resulting in death) Last	c. Due to (or as	a consequ	ence of):	50 u	العد						(0 00	142
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Вох	ath tter	ian	23b. Was decedent pregnant in the past 12 months?	1□Live birth 4□Pregnant a	2 Fetal	death 3	Ectopic Other	pregnancy					Month Month		Year
	the de	ysic	1 ☐ Yes 2 █No 9 ☐ Unknown	9□ Unknown	tario oi de	Jan 31	100001					1			
P.0	that the desired by the a	P.	Part II. Other significant conditions	contributing to death b	ut not resu	ulting in the u	nderlying	cause giv	en in Part	1.	23e. Did	tobacco	use contribute	to the cause of d	leath?
of Vital Records,	w requires that been signed b should be deta	d by									158	Yes 2	2 No 3 F	Probably 4 🔲	Jnknown
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Division	or A after Dirac in by	Certification:	4 Homicide determine	building, e	c. (Specify	()	1001, 1201	ary, omco			City or To				
J	To the Hospital or Attending Ph within 24 hours after death. To the Funaral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying	Physician: To the best	of my know	wiedne dest	h occurre	d at the tim	ne date a	and place	and due to the	Cause	s) and manner :	is stated.	
	24 hc 24 hc Fun	edical	(Check only 2 Medical Ex	aminer: On the basis of and manner st	fexaminal	tion and/or in	vestigation	on, in my o	pinion, de	ath occurr	ed at the time	, date a	nd place, and di	e to the cause(s)
	the ithin of the control of the cont	Me	29b. Signature and title of certifier				2	9c. Licens	e number			29d. D	ate signed (Moi	nth, Day, Year)	
	F ≱ F 8		X 1C C	4h_/			7	X11	MI	1		1.4	1/2/-	lou	
	/		30. Name and address of person wh	o completed cause of	leath (Item	23a) (Tunn	Print)	SIU	T	7		1.0	0/26	~ 7	
	n		CI	N	I D	77	Sou	H. (~,	5	hust	Bal	Limni	moz	1201
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	Regist		DCT 2 9 2004	hema	1	1		Paris							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item # 7 per FH C837 11/1/04 TT Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year Franco 10 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Year If Under 24 Hrs. 8. Date of Birth (Month, Day, HOSDI LA IIMORE 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 F 220-34-7486 Yrs. Director 65 Usuel Residence of Decedent should be filed within 72 hours after death with the Maryland 10a State 10b. Counts 10c. City, Town or Location item 27 is marked other than "netural", or Items 23e or 28e-f show other treumatic event, the Modical Extention of the retified at 10d. Inside City Limits 1 Yes 2 No Director rartorc 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 420 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ≥ 1 ☐ Yes Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ NO Specify: 3 DWidowed 4 □ Divorced and Mental Hygiene. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry Un K. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) randica 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) To Be Baudoin aurance 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 is n 31001 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cometery, crematory or other place) Oc. Location - City or Town, State any injury or o once. * 4 □Donation 5 □ Other (Specify) le tro 21. Signature of Furfiral Service 22. Name and Address Facility 1232 Mid-Valley Dr. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm, diate Cause (Final dise to or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner been signed by the attending physician and should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No certificate has autopsy performed 2 100 To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 2 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Mann Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Certification: 1 L atural Injury 5 Pending within 24 hours after death. To the Funerel Director: A 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Marylan		nent of Heicate of D			giene Reg. N200	4 34423
			1. Decedent's Name (First, Middle, Last)		_ `	,		2. Date of De. Month		3. Time of Death
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			MILLENMIUM // 5. Social Security Number 6. Sex			Under 1 Year	If Under 24 Hrs.	8. Date of Birt		Birthplace (State or Foreign Country)
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	Mith The I	i Dir	7575 E. Howard Re	oad			21060	0	USA	
	death	Funeral Director	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. Was	Decedent of His	spanic Origin? (Sp	ecify Yes or No		American Indian, White, etc.
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	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. item 27 is marked other then "naturel", or Items 23a or 28e-f show other treumatic event, the Medical Examinar must be notified at		Dawn Cervenka/grt 20a. Method of Disposition	20b. F	Place of Dispositio	n (Name of		Date MD	21122 20c. Location - Ci	ty or Town, State
nor	Pages nent of int: If it iry or o		1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	emoval from State	emetery, cremato	ry or other place	9)			
Baltimore,	_ E # = .		21. Signuture of Eunera Service License	Se Ald Winds at a	22. Na	me and Addres	s of Facility			
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Вох	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	M/C	23b. was decedent pregnant	3c. If yes, outcome of pregn. 1 □ Live birth 2 □ Feta		opic pregnancy			23d. Date	
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P.0	ires that the de signed by the a 1 be detached t	Phy	9 Unknown		ulting in the under	rhijaa sawaa ayy	on in Part I	23e Did 1	obacco use contrib	ute to the cause of death?
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Sor	v requir been si should	Completed	SPINAL	5TEN 958				24a. Was	an 24b We	ere autopsy findings available
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N N	Physicien: this certificated ral director,	To Be	examiner?	lospital: 1 Inpatient 2	ER/Outpatient	3 DOA Othe	D.C.		dence 6 Other	(Specify)
n 0			27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	< ?	28d. Describe	how injury occurred	
Sio	Attending or death.	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □No	296 Leasting /	Street and Number	or Rural Route Number,
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_	To the Hospital or Attend within 24 hours after death To the Funeral Directors completely filled in by the	edical Ce	(Check only 2 Medical Exami	sician: To the best of my knoner: On the basis of examina	owledge, death oc ation and/or invest	curred at the tim igation, in my of	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and mani date and place, an	ner as stated. d due to the cause(s)
	thin 2 the I	Med	29b. Signature and title of certifier	and manner stated.		29c. License				'Month, Day, Year)
	7 × 5 0		lede	M. D.						
			30. Name and address of person who co	ompleted cause of death (Ite	m 23a) (Type, Prir	nt)				1-21-0001
				DER M.D.	7445	FURNA	E BRA	WCH R	d-GLEN	R-21-2004 BURNIE TR 21060
		ate	31. Date filed (Month, Day, Year) QCT 2 9 2004	32. Registrar's Sign	ature /	0.1				
	Regist	rar	UC 6 3 4004	/ Land	V pape	act of				

		•	For State Registrar	State	of Man	yland / Dep <i>Ce</i>	artment o	f Hea	aith and eath	l Mental	Hygi Re	ene 0 0	4	34424
		0	Decedent's Name (First, Middle	e, Last)						2. Date Mont		Day	Year	3. Time of Death
	Physici /Medic		Charles W. Gre	ger, Jr.						OCT		26, 20		2:46 A M
).	Examin		4a. Fecility Name (If not institution	n, give street and nu	ımber)		4b. City, Tow	n, or Lo	cation of De	ath		4c. County	of Death	
			2216 Shindale	Avenue			Hanov	er				Anne	Arur	idel
	Funeral		5. Social Security Number	6. Sex		In yrs. last birthda) If Under 1 Y		Under 24 H Hours Mi	rs. 8. Date n. (Mont	of Birth h, Day,	Year)	9. Birth	nplece (State or Foreign untry)
	Director		214-03-2275	1₽ M 2□ F		89 Yrs.				AUG.	20,		Ma	ryland
	pur *	}	Usual Residence of Decedent 10a, State 10b, County		1	Oc. City, Town or	ocation							10d. Inside City Limits
	faryla sho	ō		Arundel		Hanover								1 ☐ Yes ZXXVo
	28a-	Director	10e. Street and Number				10f. Zip Coo	de			10	g. Citizen of V	Vhat Co	untry?
	with se or		2216 Shindale	Διζεριμε			210	176				USA		
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36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If Item 27 is marked other than "natural; or Items 23a or 28a-f show any njury or other traumatic event. If a Medical Examination in all be notified at once.	by Funeral	1 ☐ Never Married 2 ☑ Mar 3 ☐ Widowed 4 ☐ Divorced	If ¥7es. G	2 No	wii	If Yes, specify 0		Mexican, Pu Specify:	erto Rican, eti	C.)	Specify	k, White Wh	ite
Maryland 21215-0036	2 hou	ted		t's Education		16a, Dec	edent's Usual O	cupatio	n		1	6b. Kind of Bu	ısiness/l	ndustry
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a	2 sho and ts m		19a. Informant's Name/Relations				ling Address (St							ip Code)
	and ealth m 27		Arlene Greger	- wife		2216 20b. Place of Dis	Shinda		venue	, Hanov	-			F Ct-1-
Baltimore,	ges 1 t of H if ite or ot		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation	3 Removal from		cemetery, ci	ematory or other	place)	100		- 10	0c. Location -		
	tmen tant: jury		`4 □Donation 5 □Other (5			Meadowri				/30/200)4 .	Elkrido	je, l	
Ba	Departing on a support		21. Signature of Funeral Service	Heiler	na	G	22. Name and A ary L. K 250 Wash	laufr	nan Fu					dge MP, Inc.
Ĭ.	₹ <u>*</u>		23a. Part1. Enter the disease, o shock, or heart failure. List	complications that only one cause on	caused th	e death. Do not e	nter the mode of	dying, s	uch as card	iac or respirat	ory arres	st,		Approximate Interval Between
Ш	Physician		Immediate Cause (Final disease or condition	AL	z He	MER'S	DISEA	SE						Onset and Death
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И	Examiner		Sequentially list conditions,	b. Col	ZONA	-Ry Al	LTEby	DIS	CASE					3/ YEARS
	pe tis	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to		consequence of):								VEARE
	and I-tran	хап	that initiated events resulting in death) Last	c. Due to		consequence of):	<i>\(\)</i>			-				101103
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit					ID ART	Thu D	15 Ex	156					YEARS
687	ficate phys	edical		0	7001	10 /1/01								
Вох	eath certific attending p I for use as I	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, or								23d. Dat	e of deli	very
m	death e atte d for	lcia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4⊡Preg	nant at tin		☐Ectopic pregn ☐ Other (specif					Mo	nth	Day Year
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Division of Vital Records, P.O.	uires tha signed d be del		Part II. Other significant conditi	_		-	underlying cause	e given i	n Part I.	23e.	Did toba	3.0		the cause of death?
ğ	w require been si should b	ed	POST HERPET	IC NE	ura	LaiA				- []	1 🗌 Yes	2 2 No	3 Pro	obably 4 Unknown
ecc	law ras be	Completed by								24a.	Was an autopsy		Vere au	topsy findings available completion of cause of
œ	icien: The lav certiticate has ector, page 2	Con								1 🗆 🕆	perform Yes 2		leath?	2) No
<u>ita</u>	Physicien: r this certitica ral director, I	Be (25. Was case referred to medica examiner?						6. Place of D	eath (Check	only one)		
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n C	ding P. Afert funera	ë	27. Manner of Death 1 Natural 5 Pendi	ng (Mo	of Injury onth, Day Y	'e <i>ar</i>) 28b. Time Injun		Injury at Work?		28d. Desc	cribe hov	v injury occurr	ed	
Sic	ttendi death. ctor: A y the fu	cat	2 Accident invest	not be	. of lating	A h			: 2 □No	296 1 225	lion /Ctm	and and Alumb	O	ral Route Number,
\leq	t or Attendate death Director:	Certification:	4 Homicide determ	nined 286. Place	ding, etc.	· At home, farm, (Specify)	street, ractory, or	ice			or Town,		er or nu	ar noute wanter,
_	spital ours a neral filled		29a. Certifier	ng Physician: To th	ne best of	my knowledge, de	ath occurred at the	ne time.	date and pla	ice, and due t	o the car	use(s) and ma	nner as	stated.
	To the Hospital or Attending Physicien: The within 24 hours afte death. To the Funeral Director: After this certilicate he completely filled in by the funeral director, page	edical		Examiner: On the		xamination and/or								
	To th To th	Me	29b. Signature and title of certific)r			29c. Li	cense ni	umber		29	d. Date signed	(Month	, Day, Year)
			Doons	Com, 1	illes		7) Z	2832	2_		10/2	6/	2004
	2+1		30. Name and address of person	who completed car	use of dea	th (Item 23a) (Typ	e, Print)				1	4.		,
_	171			, M.D.	58	th (Item 23a) (Type 08 MA (USTRE	ET	ELL	CRIBA	€ ,	, MD	210	75
		ate	31. Date filed (Month, Day, Year	32.	Registrar's	s Signature	A. a	,						
	Regist	rair	DCT 2 9 2	nna Alem	1420	Nº 1400	-							

04-06861 Robert Hahne RJD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of M	aryland / Depa <i>Cei</i>	artment of H <i>rtificate of L</i>		entai Hyg	^{len} 2004	34425
	Physici		1. Decedent's Name (First, Middle, L. Robert Dale Ha	,				2. Date of Deat OCTOber	23, 2004	3. Time of Death 0912A. M
	/Medic Examir		4a. Facility Name (If not institution, gi Good Samaritan I	ve street and number)		4b. City, Town, or Baltimon	Location of Death		4c. County of Deat	
	Funeral Director		470-28-9178	Sex 7. Ag 1 ☑ M 2 ☐ F	e (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Oct 6,	9. Bird 1930 I11	hplace (State or Foreign untry) inois
	he Maryland 8a-f show	ector	Usual Residence of Decedent 10a. State 10b. County MD Baltimo	ore	10c. City, Town or Lo Baltin	more				10d. Inside City Limits 1 ☐ Yes 2X No
	th with the 23a or 2 ust be or	Funeral Director	1306 Blakewood C	ourt		10f. Zip Code	1222	11	0g. Citizen of What Co USA	ountry?
036	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "natural", or iteme 23e or 28e-f show event, the Medical Evantian must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 XYes 2 If Yes, Give Year or Dates:	No .	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2X No	spanic Origin? (Spe n, Mexican, Puerto I Specity:	cify Yes or No- Rican, etc.)	14. Race · Ame Black, Whit Specify: wh	e, etc.
21215-0036	filed within 72 ho Hygiene. Sther then "natur ent, toe Mexical	Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12) 12	ducation ade completed) College (1-4or	(Give life. L	dent's Usual Occupa kind of work done o DO NOT use retired inkmaker	ation Juring most of workir)	ng	16b. Kind of Business/	^{Industry} unk
Maryland 2	be filed ntal Hygic od other event, I	Be	17. Father's Name (First, Middle, Las Peter J. Hahr				18. Mother's Name		faiden Surname)	
ız	s 1 and 2 should be f Health and Mental Item 27 is marked o other traumatic eve	ပ	19a. Informant's Name/Relationship		19b. Mailin	ag Address (Street a		n Smith	City or Town, State, 2	Zip Code)
	nd 2 state at trau		Joan Hahne/spous				od Court 1			22
Baltimore,	Pagenent o		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ['4 ☒ Donation 5 ☐ Other (Special Content of the conten	(b)	20b. Place of Dispo cemetery, cren	sition (Name of natory or other place	9)	ate	20c. Location - City or	
Balt	permit. Page Department o Importent: If any injury or once.		21. Sign was of Funeral Service Lice Son Ld S	Wade, Vir	ector St Ba	Name and Address ate Anato 1timore,	s of Facility Dmy Board MD 21201	655 W.	Baltimore	Street
0	Fnysician /Medical Examiner		23a. Part 1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. ATM	the death. Do not entended. Consequence of):					Approximate Interval Between Onset and Death
68760,	tificate be executed g physician and as the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of): a consequence of):					
O. Box	The law requires that the death certificate I tile has been signed by the attending physioage 2 should be detached for use as the last	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant al	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions CHRONIC OBSTA					23e. Did tob	acco use contribute to	the cause of death?
I Records,		Completed						24a. Was an autopsy perform	prior to death?	topsy findings available completion of cause of
Vital	icien: certific rector.	Be	25. Was case referred to medical examiner?	Hospital:		Othe	26. Place of Death			
o	ing After uner	tion: To	1 Yes 2 No 27. Manner of Death 1 Quatural 5 Pending 2 Accident investigation	28a. Date of Inju	ry 28b. Time of	28c. Injury Work	at 2		nce 6 □Other (Spec w injury occurred	ify)
Division	ol or Attending after death. I Director: After d in by the fune	Certification:	3 Suicide 6 Could not l	28e. Place of Inj	ury - At home, farm, stre c. (Specify)		-	8f. Location (Str City or Town	eet and Number or Ru , State)	ral Route Number,
	To the Hospitel or Atti within 24 hours after de To the Funerel Direct completely filled in by ti	edical C	29a. Certifier (Check only one) 1 ☐ Certifying P 2 ☑ Medicel Exe	hysician: To the best miner: On the basis o and manner st	of my knowledge, death f examination and/or inv ated.	occurred at the time restigation, in my op	e, date and place, a inion, death occurre	nd due to the ca d at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
•	To the within 2 To the complet	Me	29b. Signature and title of certifier	Un		29c. License O.C.M			od. Date signed (Month October 24,	
			MATHY C.	Clipe	leath (Item 23a) (Type,	Print) 111 P	enn Stree	t, Balti	imore, Mary	yland 21201
	Sta Registr		31. Date filed (Month, Day, Year) OCT 2 9 201	4	als Signature	Sports				

			1 - For State Registrar	State of I	Marylan		artment of				giene	በ៤	34426
19.00	Physici		Decedent's Name (First, Middle, L Mary Harri							2. Date of Dea Month October	th Day	Year	3. Time of Death 12:45 P ^M
	/Medic Examin	er	4a. Facility Name (If not institution, gi				4b. City, Town,			octobel	4c. Coun	ty of Death	
	Funeral Director		5. Social Security Number 6. 534-26-3678			last birthday) Yrs.	If Under 1 Yea Months Day	r If Unde	or 24 Hrs.	8. Date of Birth (Month, Day April 1	Year)	9. Birthp	place (State or Foreign atry)
	the Maryland 28a-f show	ector	Usual Residence of Decedent 10a. State 10b. County MD Montgon 10e. Street and Number	ery		y, Town or Lo					los Citis a s		0d. Inside City Limits 1 ☆Yes 2 ☐ No
9800	within 72 hours after death with the Maryland ene. then "natural", or iteme 23e or 28e-f show then "natural" or iteme 11e modical Examinar must be notified at	d by Funeral Director	4309 Sandy Sprin 11. Marital Status 1 Never Married 2 Married 3 XiWidowed 4 Divorced	12. Was Decede Armed Force 1 Yes X If Yes, Give Year or Date	ns? □No		20866 Was Decedent of 1 Yes, specify Cu	Hispanic C ban, Mexic		τ		State ace - Americ ack, White,	ean Indian, etc.
21215-0036	ed within 72 h ygjene. ver then "natu it, the Medica	Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)	rade completed) College (1-4d	or 5+)	(Give life. L	dent's Usual Occ kind of work don DO NOT use retii sed Prac	e during mo red) tical	Nurs	se	16b. Kind of	cal	dustry
Maryland	should be fill and Mental H marked ott matic even	To Be	 Father's Name (First, Middle, Las John H. Sayler Informant's Name/Relationship 			19b Mailin	ng Address (Stree	В	arbar	(First, Middle,	ich		Codel
Baltimore, Ma	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "natural", or Iteme 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.		Melvin Harris/Son 20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 [4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice	l □Removal from Sta	ite C	4309 Stace of Disponentery, crematernal	Sandy Sp sition (Name of natory or other pl 1 Cemete . Name and Add etts Fun 02 9th S	oring dace) ery ress of Faceral	Rd., 11-1 Servi	Burtons -04	ville, 20c. Location Chela	MD .	20866
8760, 5:	ficate be executed /Medical Examiner and is the burial-transit	dicai Examiner	23a. Part1. Enter the disease or cor shock, or hear failure List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underwing Cause (Disease or injury that initiated events resulting in death) Last	a. Bladd Due to (or b. Atria Due to (or c. Urina Due to (or	ler Can as a consequ al Fibi as a consequ	n. Do not enter ncer uence of): rillat: uence of): act In: uence of):	er the mode of dy	ying, such a	is cardiac o	r respiratory arr	est.		Approximate Interval Between Onset and Death
.O. Box 68	death certi e attending od for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal at time of de	death 3	Ectopic pregnan Other (specify)	су				ate of delive	ry Day Year
S, D	sign d be	þ	Part II. Other significant conditions Alzheimers Dis		but not resu	ulting in the ur	nderlying cause g	iven in Part	1.				e cause of death?
tal Record		e Completed	25. Was case referred to medical							24a. Was a autops perform	ned? 2 XNo	prior to cor death?	osy findings available inpletion of cause of
Division of Vital	Phye this al dir	Certification; To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	28a. Date of In (Month, I	- T	ER/Outpatien 28b. Time of Injury	28c. Inju	ther: 4X N	lursing Hon	Check onI on ne 5⊡ Reside 28d. Describe ho	ence 6 ∏Ot)
DIV	or A		3 Suicide 6 Could not 4 Homicide determined	building,	etc. (Specify	"	eet, factory, office			28f. Location (St City or Town	n, State)		
	To the Hoepital within 24 hours a To the Funerel I completely filled	Medicai	29a. Certifier Tercertifing P (Check only one) 2 Medical Example 20b. Signature and title of certifier	hysician: To the be miner: On the basis and manner	s of examinat stated.	ion and/or inv	estigation, in my	time, date a opinion, de ose number	ath occurre	ed at the time, d	ause(s) and mate and place,	and due to	the cause(s)
	⊢ 3 ⊢ ŏ		30. Name and address of person who	Completed courses	f death (Item			20274			ctober		
	5 Sta	ie.	Kirti Vohra, MD	7710 E		y Blvd	., Bethe		MD 20	817			
	Registr		OCT 2 9 20	04	معمد	B	Spare	2					

State of Maryland / Department of Health and Mental Hygiene Reg. N2 0 0 4 Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) October 17, 2004 **Physician** Baby Girl Hall 7:50 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Name (If not institution, give street and number) Examiner Prince George's Medical Center Prince George's

9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 1 □ M 2 🗓 F Oct 14, Director 2004 Maryland none Usuel Residence of Decedent pamit. Pages 1 and 2 should be filed within 72 hours after death with the Marylend Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itema 23a or 28a-f show eny Injury or other traumetic event, the Medical Evantiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County MD Prince George's Hyattsville 1 ☐ Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1945 Dutch Village Drive 20785 USA Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: black Þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) none none none none 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Darryl Small Christine Hall ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Prince George's Medical Center 3001 Hospital Drive Clinton, MD 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 🛛 Other (Specify) in state 21. Signature of Euneral Service Licensee, RONALO S. Wade, 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, on heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) IMMATURITY: 22-23 WKS /Medical Examiner Examiner requiras thet tha death certificate be executed signed by tha attending physician and doe detached for use es the bunal-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury Division of Vital Records, P.O. Box 68760 Physician/Medical resulting in death) Last TEMORIAA G 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Š 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 Ves 3 700 **2**□1√0 1 🗌 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ို 1 npatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Dey Year) ar death. 28c. Injury et Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours aftar death.

To the Funerel Director: After 1 Naturel 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. edical 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature end title of certifier 29d. Date signed (Month, Day, Year) and 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 3001 Antoine 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		4	State of Maryla For State Registrer	nd / Depa		lealth and	Mental Hygi	_	34428
	*	b.	Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
П	Physicia /Medic		Robert L. Hively					25, 2004	12:30 P M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Deat	h	4c. County of Dea	ıth
#2			16 Mariner's Way, Unit l		Stevens			Queen Ani	
1	Funeral		5. Social Security Number 6. Sex 7. Age (In yr 1974) 6. Sex 64	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.			rthplace (State or Foreign ountry)
	Director		Usual Residence of Decedent	.			MAR. IZ,	1340 We	st Virginia
	rylanc how	. [O 1 01	City, Town or Lo					10d. Inside City Limits
	e Ma Sa-f s	cto	MD Queen Anne's Ste	evensvil	тте				1 Yes 2 No
	with th	Funeral Director	10e. Street and Number		10f. Zip Code	C	10	g. Citizen of What C	ountry?
	s 236	eral	16 Mariner's Way, Unit 1	11.5 12.5	2166		Sanathy Van or No	USA 14. Race - Am	oriena Indian
	ter de	-un	Armed Forces?	0.3.	Was Decedent of H If Yes, specify Cuba	an, Mexican, Puer	to Rican, etc.)	Black, Wh	
980	urs af	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify:	white
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "neturel", or Items 23c or 28a-f show ther than "neturel", or Items 23c or 28a-f show ont, the Modeal Examitter mant be polified at	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occup	ation	rking 1	6b. Kind of Busines:	s/Industry
2	within lene. than "I	npie	Elementary/Secondary (0-12) College (1-4or 5+)	life.	DO NOT use retired	d)	, and		
	filed w Hygier Ather th	Co	12 3	Co	urier	10 Matheda No.	me (First, Middle, M	Courier	
anc	ntal Hed of	Be (aluen Sumame)	
Maryland	2 should and Men is marke eumatic	^L	Harvey Hively 19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	na Address (Street	Iva Ca. and Number or Ri		City or Town, State,	Zip Code)
S	and 2 sealth ar n 27 is wer treu		Kamie MacKenzie - daughter		-			ensville,	
re,	of Health item 27		20a. Method of Disposition 20b		osition (Name of matory or other place			Oc. Location - City o	
E	Pages nent of I ant: If ite ury or o		1 ABurial 2 ICremation 3 Removal from State			l l	/28/2004	Elkridge,	MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel', or items 23s or 28a-f show ery injury or other treumatic event, the Modical Examination invalue inclined at one.		21. Signature of Funeral Service Dicensee	Ga 72	2. Name and Address ry L. Kau 50 Washir	ss of Facility Ifman Fur Octon Bly	meral Home		idge MP, Inc. 21075
П	£,		23a. Part1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line.						Approximate
	Physician		Immediate Cause (Final disease or condition	ND	JWDIS				Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a cons	equence of):					
н		-	Sequentially list conditions, if any, leading to immediate b. Due to (or as a cons	equence of):					
1	uted f insit	min	cause. Enter Underlying Cause (Disease or injury	- 1					
C.	be executed ician and burial-transit	Examiner	that initiated events c	equence of):					
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89	ng ph	Med	IF FEMALE:		-				
Вох	death certifica e attending ph id for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months?	atal death 3	Ectopic pregnancy	,		23d. Date of de Month	livery Day Year
o.	the a	ysic	1 Yes 2 No 4 Pregnant at time of 9 Unknown	f death 5	Other (specify)				32,
٥.	The law requires that the te has been signed by the bage 2 should be detache	Ph	Part II Other significant conditions contributing to death but not r	esulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribute (o the cause of death?
Records,	uires Isign Id be	d by	PERIPHERAL VASUR	AR 1	DISEAS	E	1 □ Yes	s 2 2 √ 10 3 □ F	robably 4 🗆 Unknown
0 0	s beel	Completed					24a. Was an		utopsy findings available
Re	The law ate has page 2 s	mo					autopsy perform 1 Yes 2		completion of cause of
Vital	icien: Th certificate rector, pag	ВеС	25. Was case referred to medical examiner?			26. Place of De	ath (Check only one		
of V		To	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatier		4 Nursing F		nce 6 □Other (Spe	ecify)
D C	ing P Viter t unera	on:	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor		28d. Describe how	w injury occurred	
Sio	Attending r death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	h		Yes 2 No	296 Leasting /Ctm	and Alumba s on C	Total Bassa Musebas
Division	or At after of Direction by	Certification;	4 Homicide determined 28e. Place of Injury - At building, etc. (Spe	cify)	евт, тастоту, оптсе		City or Town,	eet and Number or A State)	urai Houte Number,
_	spital nours nerel filled		29a. Certifier 1 Certifying Physicien: To the best of my k	nowledge, deat	h occurred at the tin	ne, date and place	, and due to the car	use(s) and manner a	s stated.
	To the Hospital or Attending Physwithin 24 hours after death. To the Funerel Director: After this completely filled in by the funeral di	edicai	(Check only 2 Medicel Exeminer: On the basis of examinand manner stated.	nation and/or in	vestigation, in my o	pinion, death occi	urred at the time, da	te and place, and du	e to the cause(s)
	To the within To the comp	Ň	29b. Signature and title of centifier		29c. Licens	e number	29	d. Date signed (Mon	th, Day, Year)
			Xeted (X 20)C	UED	17	16360	+ (Jet 25	2004
	16		30. Name and address of person who completed cause of leath (II	ет 23а) (Туре,	Print)	A. M.C.	ALLKANA		0.401
			31. Date filed (Month, Day, Year) 32. Registrar's Sig	DESI 6	加巴巴) 200 CJ	numors	12 mg	21401
	Sta Registr		OCT 2 9 2004	& Shar	the s				
			UUI 6 3 LUU4 PRESENTE	1					

State of Maryland / Department of Health and Mental Hygie 20 0 4 34429 Certificate of Death

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	1.	Deceden
sician edical		Ro

			Decedent's Name (First, Middle, Las	1)			504	2. Date of De		Vasa	3. Time of Death	
	Physicia /Medic		Ronald S. Isa		Octob	Pay Year 24. 2004 11:50a M						
	Examin		4a. Facility Name (If not institution, give	4b. City, Town, or Location of Death				4c. County of Death				
	Funeral Director		216-68-8309		napolis ast birthday) Yrs.	Annapo If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		dh	9. Birth Cou Mary	place (State or Foreign intry)	
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City	/, Town or Loc	ation					10d. Inside City Limits	
	he Marylan 18a-f show ulified at	Funeral Director	Maryland Anne		apolis				40	(111)	1 ☐ Yes 2X No	
	with the or 2		10e. Street and Number	Unit 104	T-T	10f. Zip Code	1 401		10g. Citizen			
	eath	erai	2016 Govenor Th	12. Was Decedent Ever in U.			1401	necify Yes or No	n- 14. F	Race - Ameri	USA ican Indian.	
336	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other then "natural", or Items 23a or 28a-f show or other treumatic event, the Medical Examis at must be rediffed at	by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Yes, specify Cuba ☐ Yes 2☐xNo	lispanic Origin? (S an, Mexican, Puerl Specify:	o Rican, etc.)		Black, White, ec <i>ify:</i> B1a	, etc.	
Maryland 21215-0036	n 72 hou "natura edicul E	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	(Give k	ent's Usual Occup ind of work done of O NOT use retired	during most of wor	rking	16b. Kind o	f Business/In	ndustry	
12	withi ene. then	duc	Elementary/Secondary (0-12)	mentary/Secondary (0-12) College (1-4or 5+)							Service	
9	filed Hygid Sther ent, I	a	17. Father's Name (First, Middle, Last)	U			18. Mother's Nar	ne (First, Middle				
lan	should be fund Mental H s marked of umatic eve	ToB	Stephen (G. Isaacs			Anna	Duva11				
aryl	2 should be filed withir and Mental Hygiene. Is marked other then eumatic event, the Me		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailing	Address (Street	and Number or Ru	ıral Route Numb				
	of Health a litem 27 ls		Anna Isaacs (Mo				r Thoma		en wa		21401	
Baltimore,	permit. Pages 1 a Department of He Importent: If iten any injury or oth		20a. Method of Disposition 1	Removal from State Re	emetery, crem State	ition (Name of atory or other place Memor	i ¬ 1	30/04	20c. Location	on - City or T		
Balt			21. Signature of Funeral Service Licen	S99	22.	Name and Addres	ss of Facility					
			Jacky S. Reese Mod483 Will. Reese & Sons Mortuary, P. A. 21101 23a. Part1. Enter thi disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between									
	Physician		Immediate Cause (Final disease or condition	MULTIPLE	> ,	NTVRI	EC				Onset and Death	
1	/Medical		resulting in death)	Due to (or as a consequ								
	Examiner		Sequentially list conditions.	b								
VA	Sit 9d	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):							
V , .	and and Il-tran	Examiner	that initiated events resulting in death) Last	c Due to (or as a consequ	uence of):			-				
09/	be e sician buria	alE	U		,							
687	tlicate g phy: as the	edic	``	d								
ecords, P.O. Box 68760,	res that the death certiticate be executed igned by the attending physician and be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 🗆	Ectopic pregnancy Other (specify)				Date of delive Month	ery Day Year	
٦.	that the od by detail		Part II. Other significant conditions of	ontributing to death but not resu	ulting in the un	derlying cause give	en in Part I.	23e. Did	tobacco use c	ontribute to t	the cause of death?	
ds	quires n sign ald be	d by						10	Yes 2 No	3 🗆 Prot	babły 4 ∏Unknown	
Records,	law requiras been si 2 should l	Completed						24a. Was	an 24	b. Were auto	opsy findings available ompletion of cause of	
Œ	0 - 0	ШО						auto perfe	psy ormed? 2 \Bo	death?	2 No	
Vital	icien: Th certificate ector, pag	BeC	25. Was case referred to medical				26. Place of Dea					
Ž	d s	To	examiner? 1 🔀 es 2 🗌 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3 □ DOA Oth	er: 4 Nursing H	lome 5□Resi	dence 6 🔀	Other (Specia	M At Scene	
0 0			27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun World		28d. Describe DRIVER			DLUED IN	
Sio	or Attending Ifter death. Director: Afte in by the tune	cati	2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be		11:47 A		Yes 2 No	cours	102		10-11-11	
Division of	l or Al after of Direc	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	me, rarm, stre	et, ractory, onice		City or To	wn, State)		E POMV , M D	
_	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely tilled in by the	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Exen	ysician: To the best of my knowiner: On the basis of examination and manner stated.	wledge, death tion and/or inve	occurred at the tin estigation, in my o	ne, date and place pinion, death occu	, and due to the	cause(s) and	manner as s	stated.	
	o the o the omple	Med	29b. Signature and title of certifier	and majings stated.		29c. Licens	e number		29d. Date sig	ned (Month,	Day, Year)	
	F 5 F ŏ		· anast			OCME	Ε		Octob	er 25,	2004	
	3		30. Name and address of person who a	completed cause of death (Item	23а) (Туре, Р	111 Penr	Street,	Baltim	ore, Ma	arylan	d 21201	

State

Registrar

31. Date filed (Month, Day, Year)

OCT 2 9 2004

Souls

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygien?

			1 - For State Ragistrar	State of Marylan		artment of H rtificate of			Reg. No.	004			
7	Physici /Medio Examir	al ier	1. Decedent's Name (First, Middle, La William 4a. Fecility Name (If not institution, giv	TONN KAPA			r Location of Deal	2. Date of Dea Month 10/2	26/2 4c.				
	Funeral Director		Ridgeway Manor 5. Social Security Number 6. S 215-07-4088 Usuel Residence of Decedent	NUTSING HOME Sex 7. Age (In yrs. 1M 2 F 92	e last birthday) Yrs.		If Under 24 Hrs Hours Min		h	9 Birth	pplace (State ountry) Yland		
21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28e-f show aumatic avent. If a Medical Examined mustic avent, If a Medical Examined Fran	rai Director	10a. State 10b. County Maryland Howar 10e. Street and Number 6044 Augustine	rd El	y,Town or L kridg	e 10f. Zip Code 21075			Uni	zen of What Co	ates		
	hours after deal tural', or ttems ?	ed by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's E	12. Was Decedent Ever in U. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: WWI	I	Was Decedent of HI Yes, specify Cub 1 Yes 2 No dent's Usual Occup	Specify:	Specify Yes or No- to Rican, etc.)		4. Race - Ame Black, White Specify: What and of Business/	nite		
	filed within 72 Hygiene. other than "na ant, It a Medic	Completed	(Specify only highest gra Elementary/Secondary (0-12) 10th	College (1-4or 5+)	(Give	kind of work done DO NOT use retire O Engra	during most of wo	rking me (First, Middle,	Pri	nting			
Maryland	2 should be fill and Mental H Is marked off	To Be	17. Father's Name (First, Middle, Last, Henry Kappauf 19a. Informant's Name/Relationship (Type, Print)		ng Address (Street	Annie	Hall ural Route Numbe	er, City or	Town, State, Z		1	
Baltimore, M	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marke any injury or other treumatic <u>once.</u>		Dorothy Kappau: 20a. Method of Disposition 1 A Burial 2 Cremation 3 C 4 Donation 5 Other (Specil 21. Signature of Funeral Service Lices	Removal from State Cr	ownsv teran	August position (Name of malery or other plains of the complet of	ery 10/	29/2004	Cr	ownsvi	lle,	2107! MD 21229	
100	Pnysician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediete Cause (Final disease or condition resulting in death)	a. Due to for as a conseq	Do not en	ter the mode of dyir	ng, such as cardia	c or respiratory ar			Approximat Interval Bet Onset and I	e ween	
1760,	ate be executed typician and the burial-transit	ical Examiner										<u>.</u>	
vision of Vital Records, P.O. Box 68	death certific e attending p id for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetel death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)							23d. Date of delivery Month Day Year		
	The law requires that the ate has been signed by th bage 2 should be detache		, , , , , , , , , , , , , , , , , , , ,							cco use contribute to the cause of death? 2 No 3 Probably 4 Minknown			
	Attending Physician: f death. setor: After this certifica by the funeral director, I	e Completed	25. Was case referred to medical				26 Place of Do	1 ☐ Yes	rmed? 2 No	24b. Were au prior to death?	topsy findings ompletion of c	available ause of	
		ToB	examiner? 1 Yes 2 No 27. Manner Death 1 Maiural 5 Pending 2 Accident investigation	26. Place of Death (Check only one) Other: 4 Warring Home 5 Residence 6 Other (Signature) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? M 1 Yes 2 No							ify)		
		al Certification;										ber,	
	To the Hospital or within 24 hours after To the Funerel Dir completely fitted in I	Medical	(Check only 2 Medical Example) 29b. Signature and title of certifier	minar: On the basis of examina and manner stated.	tion and/or in	ivestigation, in my o	opinion, death occ	urred at the time,	date and	place, and due	to the cause(s		
1	3/		30. Name a address of person who	completed cause of death (Item		Print) edou'4	Rd. C	ators n	'Cli	Mo	2122	-8	
	Sta Regist		00T 2 9 2004	Jos. Hagistral a digital	4	10.31							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month PM 10-27-2004 William H. Kraft 6:45 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 529 Shipley Rd. Linthicum, MD 21090 Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1√2 M 2 □ F Director 216-20-2239 78 5-20-1926 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic avant, If a Medicul Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Anne Arundel 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 50 or Items 23a 529 Shipley Rd 21090 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. e filed within 72 hours after al Hygiene. other then "natural", or Ite 1 Tyes 2 No If Yes, Give 8 1944 Year or Dates 3 1946 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐xNo þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Trucking Warehouseman 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any finity or other traumatic avant 2008. 18. Mother's Name (First, Middle, Maiden Surname) Be 2 William B. Kraft Isadora Hatfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nora Lee Kraft/ Wife 529 Shipley Rd. Linthicum, MD 21090 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State Bayview Crematory 1 4 ☐ Donation 5 ☐ Other (Specify) 11-01-2004 Baltimore 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne, MD 21. Signature of Funeral Service Licensee Ambrose 2719 Hai 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PROSTATE Physician METASTATIC disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, I any, Luding to him ediatocause. Enter Underlying Cause (Disease or injury that initiated events Qualto (or as a nonsequence of): Examiner certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. | the detached 9 Unknown 9 ☐ Unknown by signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 No 1 ☐ Yes 2 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28c. Injury at Work? 28d. escribe how injury occurred 28b. Time of After t Certification: tha Hospital or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation ☐ Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide a Funaral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 16354 28,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AGNES 900 CATON ANE BALTIMORE Ñ COLE 31. Date filed (Month, Day, Year)

OCT 2 9 32. Registrar's Signature State Registrar

William H. KRAF

			1 - For State Registrar	State	of Marylar	•	artment of rtificate o				iene 	lı	34432	
			Decedent's Name (First, Mid	dle, Last)			rimodio o	Douin		Date of Deat	h		3. Time of Death	
	Physic /Medi		Genevieve	Jursk		Korde	cki			Month October	-	Year 004	8:10 am M	
	Examir	ner	4a. Facility Name (If not instituti	-	umber)		4b. City, Town	,	of Death		4c. County of	of Death		
	Funeral		Franklin Square 5. Social Security Number	e Hospital	7. Age (In yrs.	last birthday)	ROSSVI If Under 1 Yea	If Under	24 Hrs. 8.	Date of Birth	Balti		place (State or Foreign	
	Director		220-05-7665	1□M 2 X F	82	Yrs.	Months Day	s Hours	Min.	Date of Birth (Month, Day, 12/3/19		Cour	vland	
	and w		Usual Residence of Decedent 10a. State 10b. Coun	tv	10c. Cit	ty, Town or Lo	ocation						10d. Inside City Limits	
	Maryl f eho	lor	Maryland Balt									'	1 ☐ Yes 2 No	
	72 hours after death with the Maryland natural', or Items 23a or 28s-f ehow disal Examinat must be notilled at	Directo	10e. Street and Number	шоте	LS:	sex	10f. Zip Code)		10	0g. Citizen of W	hat Cour	ntry?	
	23a c	raiD	910 Hyde Park 1	Road			21221				U. S. A	4.		
	ltems rerm	Funeral	11. Marital Status	12. Was Dec	edent Ever in U orces? 2 XNo	.S. 13.	Was Decedent of If Yes, specify Cu	f Hispanic Orig uban, Mexican	gin? (Specif , Puerto Ric	y Yes or No- an, etc.)	14. Race		can Indian, etc.	
036	hours af	by	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	If Vac G	ive		1□Yes 2\N	o Specify:			Specify:	Whi	i + 0	
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land	Aental Aental rked tic ev		Stanlev Ju	rski				Don	othy	Zak	rzewski			
Mary	2 sho and h is ma	•	19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailie	ng Address (Stree						Code)	
	s 1 and f Health itsm 27 other tr		Walter J. Korde	cki, Jr.	(Son)	1747	Weston esition (Name of	Avenue	Park		Maryla			
more,	9 = 5		1 🖾 Burial 2 □ Cremation 1 □ Donation 5 □ Other		State	emetery, crei	matory or other pi	· 1	10/29)	20c. Location - C			
a	mit. Pa partmer portent: / injury		21. Signature of Funeral Service		I TO.	22	ary Ceme 2. Name and Add	ress of Facility	2004		Dundalk	., Ma	ryland	
ň	F F F G		Michael	1 Selle	5-1	B ₁	ruzdzins 407 Old	ki Fund Easteri	eral H n Aver	iome PA	sex. Ma	rvla	and 21221	
			23a. Pert1. Enter the disease, shock, or heart failure. Li	complications that it only one cause on	caused the deatl each line.	h. Do not ent	er the mode of dy	ying, such as	cardiac or re	spiratory arre	st,		Approximate Interval Between	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a		TEST	rue c	ardi	d Muy	op artl	Ly.	1	Onset and Death	
	Examiner			Due to	(or as a consec	(Jence of):	a An	400	. 1	7,20	1	1	1000	
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	Due to (or as a consequence of):						317 1300			
	executed in and rial-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c										
8/00,	bur bur	cal E	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Due to	(or as a consequ	uence ot):								
20	# × 6	- 5		d										
X Q Q	death certifica attending ph	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna		Ectopic pregnan	cv			23d. Date		*	
_	ie death the atter hed for u	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nant at time of de		Other (specify)				Monti	h	Day Year	
7.	w requires that the de been signed by the should be detached										oute to th	ne cause of death?		
vitai necords,	quires n sign uld be	d by		-iver	cirr	hon	7			1 Yes 2 No 3 Probably 4 Unknown				
000	law rec as bee 2 shoi	piete		As U.te.s						24a. Was an 24b. Were autopsy findings available				
Ĕ	The ate h page	Completed								autopsy perform	ed? de	lor to con lath? ∐Yes	npletion of cause of	
	ysician: The is certificate hadirector, page	Be	25. Was case referred to medical again and a sample?											
5	al this	1: To	a patient 2 Envoupagent 3 DOA 4 Nursing Home 5 Hesidence 6 Dother (Specify))			
0	nding ath. r: Afte e fune	atior	27. Mannsr of Death 1							200011201101	scribe now injury occurred			
DIVISION	r Atts ler ded irecto irecto	ertification:	3 Suicide 6 Could 4 Homicide deten	mined 286. Place	of Injury - At ho	me, farm, str	eet, factory, office	9	28f.	Location (Stre City or Town,	et and Number State)	or Rural	l Route Number,	
2	oital o urs aff aral Di	O												
	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	edicai	(Check only 2 Medica one)	ing Physician. To the b I Examiner: On the b and man	s best of my know asis of examinat ner stated.	wiedye, death tion and/or inv	roccurred at the t vestigation, in my	time, date and opinion, death	i piace, and h occurred a	due to the cat it the time, dat	use(s) and mann te and place, an	d due to	ated. the cause(s)	
	To the within To the complete	Me	29b. Signature and title of certifi	er a	_			ise number		29	d. Date signed (Month, [Day, Year)	
1			>	150	1 D	0.		435	5501	3	10/2	$\cdot 7/$	04	
	6		30. Name and address of person	1 6	se of death (Item		Print)	m	D (P	ALIK	RINI	76	, MD21221	
	Sta	te	31. Date filed (Month, Day, Year	JOHN 32. F	Registrar's Signat	hire	112		KI CE	MUL	, whi	-10	·, 140 (122)	
	Registr		OCT 2!	1 2004	renewa	G	Anne	/						

B.K.S

Physicia	an	State RegistraMFND TTF 1. Decedent's Name (First, Middle)	e, Last)				2. Date of Death Month	Day	Year	3. Time of Death
Medic	al	Garland Kal		-1	4h Cib. Town		OCT.	19, 200		0935 A
amin	er	4a. Facility Name (If not institution 4255 NICHOLAS		/		r Location of Death MORE CITY		4c. County of	of Death	
eral ctor		5. Social Security Number and 283–14–2058 Usual Residence of Decedent	6. Sex 7. A 1 M 2 □ F	ge (In yrs. last birthday, 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 27,	Year) 1917	9. Birthpi Coun	lace (State or Fore try) Dhio
	ō	10a. State 10b. County		10c. City, Town or Le	altimore				11	0d. Inside City Lin
	rect	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wi	hat Coup	
	io	4255 Nicholas	Avenue			1206				шут
	by Funeral Director	11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced	If Yes Give	?]No		lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race Black Specify:	- America , White, e	etc.
1	Completed	15. Deceden (Specify only highe Elementary/Secondary (0-12)	t's Education st grade completed) College (1-4or	(Give	dent's Usual Occupi kind of work done of DO NOT use retired	eation during most of work d)	ing 1	6b. Kind of Bus	iness/Ind	lustry
	Com	unk	unk		aintenanc	ce		mot	els.	
	Be	17. Father's Name (First, Middle,	Last)		unk	18. Mother's Name	First, Middle, Ma			uı
	2	19a. Informant's Name/Relations	hip (Type, Print)	19b. Maili	no Address (Street	and Number or Rura	al Route Number	City or Tourn S	tate Zin	Code
		Garland E. Kal				Avenue B			1206	
once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☒ Other (S	3 □Removal from State	20b. Place of Dispo cemetery, crea				c. Location · C		
- Suce		21. Signature of Funeral Service Ronal d		geotor S	2. Name and Addres tate Anato altimore,	omy Board	655 W. 1	Baltimo	re S	treet
	ledical Examiner	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Ener underlying Cause (Disease or injury that initiated events resulting in death) Last	aDue to (or as b	oscleratic s a consequence of): s a consequence of): s a consequence of):	Cardiovas	scular Di	sease			Interval Between Onset and Death
	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Month		y Day Year
	þ	Part II. Other significant condition	ons contributing to death t	but not resulting in the u	nderlying cause give	en in Part I.		cco use contrib		cause of death?
	Be Completed	25. Was case referred to medical				26. Place of Death		d2 dea	or to com ath?	sy findings availa pletion of cause
	Certification; To E	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin 2 Accident investig 3 Suicide 6 Could returned determ	not be 28e. Place of In	the state of the s	28c. Injury Work M 1 1	4 Nursing Hor at ? at ? Yes 2 No	ne 5 Residence 28d. Describe how 28f. Location (Stree City or Town, S	injury occurred		
.	₩.						and due to the caus	se(s) and mann	er as sta	ted.
		Check only 2V Medical	g Physician: To the best Examiner: On the basis of	of my knowledge, death of examination and/or inv	restigation, in my op	ie, date and place, a pinion, death occurre	ed at the time, date	and place and	t of aub b	he cause(s)
	ledical	29a. Certifier (Check only one) 29 Medical 29b. Signature and title of certifier	and manner st	of examination and/or inv	estigation, in my op	pinion, death occurre	ed at the time, date	and place, and	d due to t	he cause(s) ey, Year)

Physici		State of 23a-b, 27 Registrar 1. Decedent's Name (First, Middle, Last)			2. Date of	Death	04 3	3. Time of Dea
/Medic		Anna Nicole King			Octo	per 24,	2004	06:33 A
Examin		a. Facility Name (If not institution, give street and numb	ber)	4b. City, Town, or I			unty of Death	
		St. Agnes Healthcare		Baltimo	re			
Funeral		1 M 2 G E	. Age (In yrs. last birthday, Yrs.	Months Days	If Under 24 Hrs. 8. Date of Hours Min. (Month,	Birth Day, Year)	9. Birthpla Count	ace (State or Fo
Director		214-73-0880 X		20	OCT.	4, 2004	Mary	land
yland		10a. State 10b. County	10c. City, Town or L	ocation			10	d. Inside City L
e Mar	ctor	MD						1 Yes 2
ith th	Director	10e. Street and Number		10f. Zip Code		10g. Citizen	of What Count	ry?
s 23e	ral	1209 Washington Blvd.		21230		USA		
ler de Item	Funeral	11. Marital Status	ent Ever in U.S. 13.	Was Decedent of His If Yes, specify Cuban	panic Origin? (Specify Yes or , Mexican, Puerto Rican, etc.)	No- 14.	Race - America Black, White, e	
urs af	by F	Never Married 2 Married 1 Yes 2 If Yes, Give Year or Date	es:	1 ☐ Yes 2 XNo	Specify:	Spe	city: whi	te
be filed within 72 hours after death with the Maryland tal Hygiene. And other then "naturel", or Items 23e or 28a-f show event, the Medical Examiner must be notified at	ted	15. Decedent's Education	16a, Dece	edent's Usual Occupat	ion	16b. Kind o	f Business/Indu	ustry
ithin 7	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4	for 5+)	e kind of work done du DO NOT use retired)	ring most of working			•
led w lygier her th	Cor	N/A	I	nfant			[nfant	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23e or 28a-f show eny injury or other traumatic event, Ite Medical Examiner must be notified at once.	Be	17. Father's Name (First, Middle, Last)			8. Mother's Name (First, Mid	dle, Maiden Sun	name)	
should tnd Men s marke umatic	ို	Antonio Wellons 19a. Informant's Name/Relationship (Type, Print)	10h healt		Michelle King			
d 2 si th an traur		Michelle King - mother			nd Number or Rural Route Nu			
t and Health tem 27 other tr		20a. Method of Disposition		osition (Name of imatory or other place)	n Blvd., Balt		1D 212: on - City or Tow	
Pages nent of I ant: If ite ury or o'		1 Surial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		matory or other place) 11 Cemeter			lyn Parl	
nit. F artme orten injur	1.	21. Signature of Funeral Service Licensee	2:	2. Name and Address	of Facility	-		
permit, Departr Import eny injo		Mc K. Hadama	Ga:	ry L. Kauf	man Funeral H	ome@Mea	dowridg	ge_MP, I
		23a. Part1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each	ised the death. Do not en-	ter the mode of dying,	ton Blvd., Fl such as cardiac or respirator	kriage, y arrest,	1	Approximate
Physician		Immediate Cause (Final						nterval Betwee Onset and Dea
/Medical		disease or condition resulting in death) a. Asphysical	as a consequence of):					
Examiner		Sequentially list conditions b. Over1a	ay					
P #	iner		as a consequence of):					
and trans	Examiner	mat initiated events						
cate be executed physician and the burial-transit		Due to (or	as a consequence of):					
icate physis	dical	d						
The law requires that the death certifica ate has been signed by the attending pt bage 2 should be delached for use as the	hysician/Me	F FEMALE: 23c. If yes, outcome	me of pregnancy					
leath atter	ciar	in the past 12 months?	h 2 Fetal death 3	Ectopic pregnancy Other (specify)			Date of delivery Month D	ay Year
at the de by the a tached	hysi	1 ☐ Yes 2 No 4 ☐ Pregnan 9 ☐ Unknown 9 ☐ Unknown				- 1		
res that igned b	by P	Part II. Other significant conditions contributing to deat	th but not resulting in the u	ınderlying cause given	in Part I. 23e. Di	d tobacco use co	ontribute to the	cause of death
w require been sig should b					1(ÌYes 2□No	3 Probab	oly 4 Unkr
law re	ompleted				24a. W		b. Were autops	y findings avai
sicien: The law certificate has l irector, page 2 s	E				au pe 1 X Yes	topsy rformed? s 2 ☐ No	death?	iletion of cause
slen: artifica ctor,	Be C	25. Was case referred to medical examiner?		2	6. Place of Death (Check onl		70103 2	
hysic his ce	2	1X Yes 2 No Hospital: 1 ☐ Inpa		04	4 Nursing Home 5 Re		other (Specify)	
ing P	on:	27. Manner of Death 1 □ Natural 5 □ Pending 28a. Date of I 10-24th	10 1 28b. Time of 5:40 5	Work?		e how injury occ	urred	
	ertification:	2 Accident investigation found	found		s ² X ^{No} subject	overla	id duri	ne co-
ttenc death tor: the	ŧ	4 Homicide determined 286. Place of building,	Injury - At home, farm, str., etc. (Specify)	reet, factory, office	28f. Location City or 1	(Street and Nui Town, State)	nber or Rural F 011 Let	Route Number.
or Attencatter death	(T)	bed at 29a. Certifier 1 Certifying Physician: To the be		h account of the time.		re, Mar	yland	
pitel or Attencours after deathers after Director:	O		ist of my knowledge, death	n occurred at the time,	date and place, and due to the	e cause(s) and	manner as state	ed.
9 Hospitel or Attence 24 hours after death Funerel Director: etely filled in by the	O	2 miedical examiner: On the basis	s of examination and/or in	vestigation, in my opin	ion, death occurred at the time	e, uate and plac	e, and due to th	e cause(s)
o the Hospitel or Attend within 24 hours after death o the Funerel Director: ompletely filled in by the	edical C	Check only 2 medical examiner: On the pasis	s of examination and/or in	29c. License n		29d. Date sign	ned (Month, Da	y, Year)
he Hospite in 24 hours he Funerel pletely filled	edical C	one) 2 Medical Examiner: On the basis	s of examination and/or in			29d. Date sign		y, Year)
To the Haspitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical C	one) 2 Medical Examiner: On the basis	<i>₩</i>	29c. License n OCME		29d. Date sign	ned (Month, Da	y, Year)

				oartment of Health and Mental Hygiene 0 0 L	34435
ı	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Ribert Lowis	2. Date of Death Month CLOCK AT, 2006	3. Time of Death 7.25 A M
	Examin		4a. Facility Name (If not institution; give street and number)	4b. City, Town, or Location of Death 4c. County of Dea NA NA	th
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	y) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birth Months Days Hours Min. (Month, Day, Year)	thplace (State or Foreign puntry)
	Maryland 8-f show iffed at	tor	10a. State 10b. County 10c. City, Town or 1 Baltim	Location 70re	10d. Inside City Limits 1 2 Yes 2 ☐ No
	h with the	Funeral Director	10e. Street and Number 776 CroSS St.	10f Zip Code 10g. Citizen of What Co	ountry?
980	72 hours after death with the Maryland naturel', or tems 23e or 28esf show Jigal Exam is a ment to motified at	by		3. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1□ Yes 2☑No Specify: Specify: Specify:	
21215-0036	within ene. then "	Completed	(Specify only highest grade completed) (Giv	cedent's Usual Occupation We kind of work done during most of working DO NOT use retired) UND KERPER GIOIF COUNT	
Maryland 2	should be filed nd Mental Hygi markad othar imatic evant,	To Be C	17. Father's Name (First, Middle, Last) William Lewis	18. Mother's Name (First, Middle, Maiden Sumame) Mollie Jennings	
	and 2 sho ealth and n 27 Is m		Caroll Lewis-exwire 513	iling Address (Street and Number or Rural Route Number, City or Town, State, 2 2 Chalyrove Ave. Bulto, MD 2/2	Zip Code) 215
Baltimore,	Pages 1 nent of He int: If iten iry or oth			position (Name of PARK 10-30-04 Randall Stave)	Town, State
Balti	parmit. Page Department Important: If eny injury or		21. Signatu of Fueral Service Linese	22. Name and Address of Facility MY P. Murch FIH 270 Fredhilton Poss Ba	Ho. MD
P. Ya	Physician /Medical Examiner		shock, or heart tailure. List only one cause on each line.	onter the mode of dying, such as cardiac or respiratory arrest,	Approximate Interval Between Onset and Death
8760, 🗡		al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):		
P.O. Box 687	death certif e attending d for use a	Physician/Medical		3☐Ectopic pregnancy 23d. Date of del Month	ivery Day Year
	luires that t n sign a d by lld be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	c A O a	o the cause of death?
Division of Vital Records,	icien: The law requires that the certificate has been signad by the rector, page 2 should be detache	Completed	Hyperkuson	24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes	utopsy findings available completion of cause of
Vita		o Be	25. Was case referred to medical examiner? 1 Yes 2 Hospital: 1 Inpatient 2 ER/Outpatient	26. Place of Death (Check only one) ent 3 DOA Cther. 4 Nursing Home 5 Residence 5 Other (Spe	civi Herio
ion of	ding After fune	atlon: T	27. Manyfer of Dealto 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	of 28c. Injury at 28d. Describe how injury occurred	103/102
Divis	al or Attendi after death. I Director: A d in by the fu	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office 28f. Location (Street and Number or Ru City or Town, State)	ural Route Number,
	To the Hospitel or Attent within 24 hours after deatt To the Funeral Director: completely filled in by the	edical C	29a. Certifier (Check only one) 1 Certifying Physician. To the basis of examination and/or in and manner stated.	ath occurred at the time, date and place, and due to the cause(s) and manner as investigation, in my opinion, death occurred at the time, date and place, and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and utile of certifier MD	29c. License number 29d. Date signed (Moht)	h, Day, Year)
	3		30. Name and address of person who completed cause of death (Item 23a) (Type	3. Print) Hamile Rd Balt Mi	D 21210
٠.	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	arke	

Robert Lewis Whiley 725Am

State of Maryland / Department of Health and Mental Hygie () 34436 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3 Time of Death Month LEONELLI Physician TERESA OCTOBER. 3:30 AM 2004 26 /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner KALTIMORE LUZERNE AVENUE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) Funeral Months 1 □ M 2 💢 F 92 216-28-0288 Director July 4. 1912 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours efter death with the Meryland 10a. State 10c. City, Town or Location 10d. Inside City Limits tem 27 is marked other than "naturel", or flems 23s or 28e-f show other traumstic event, the Medical Examinal must be notified at 1 TYYes 2 □ No Baltimore Funeral Director Maryland N/A 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 11 North Luzerne Avenue 21224 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Detes: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: White Specify: <u>ک</u> 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12)
4th Grade Health end Mentel Hygiene. em 27 is marked other than College (1-4or 5+) Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Archangelo Stefanelli Chafia Anna 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Department of Health e important: If item 27 is any injury or other tra-Mrs. Patricia Fortner (dghtr) 11 N. Luzerne Avenue, Baltimore, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 10/28/04 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign use Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician immediate Cause (Final disease or condition resulting in death) Medicul a DEMENTIA 12 YRS Examiner Due to (or as a consequence of) Completed by Physician/Medical Examiner physician and s the buriel-trensit The law requires thet the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of) attending p Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 (2/No 1 ☐ Yes 2 ☐ No ours efter death.

•rai Director; After this certifica filled in by the funerel director, Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 27. Menger of Deeth Medical Certification: 28d. Describe how injury occurred Injury at Work? 5 Pending investigation 1 Naturel 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital within 24 hours e To the Funeral C completely filled 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCTOBER 26 D00603Z 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5505 HOPKINS BAYVIEW CIACLE, BALTIMORE, MD 21224 JEHNIFER HAYASHI, NO 31. Dete filed (Month, Day, Year) 32. Registrar's Signature

DHMH 16 Rev 6/95

State

Registrar

2004

State of Maryland / Department of Health and Mental Hygiene 001 34437 Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Odeth. 27, 2004 Year **Physician** Laura T. Martini 8:15a M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Middle River If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 4, 1916 Ivy Hall Nursing Center 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 217-05-4352 88 Yrs. Maryland Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Middle River Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 3512 Dahlia Lane 21220 USA or Items 23a by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Item any injury or other traumatic event, Ita Mental Properties. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Tin Mill Beth Steel 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Spenek Walter Nagrabski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valerie Dimmer/daughter 11318 BirdRiverGrove Road WhiteMarsh MD 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State HolyRosaryCemetery 11/1/04 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ConnellyFuneralHomeofEssex 300 Mace Ave. Baltimore MD 21221 Part1. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death .Atheroscleron'c Cardiovascular Disease Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Inecuras, r.C. Box 68760, burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. the attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? jo Month Year 5 Other (specify) signed by the a 9 Unknown 9 Hillnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably ♣☐Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 certificate 2□ No 1 ☐ Yes 2 No 1 Yes director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1- Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident completely filled in by the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide the Hospitel 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21221 201-109 Back River Neck RU MAHMOOD 32. Regutrar's Signature State 9 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Item 25 per me 6839 1-18-05 tas of Death

			1- For Amend Item 25 per me G839 1-18-05 tas Certificate of Death	Mental Hygie	12eUU4	34438
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death Q. 20 AM
1	/Medic	cal	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea	October 3	27, 2004 4c. County of Death	1 '
1	Examin	ier	BON Secours HOSPITAL BALTIMORE		NA	
	Funeral Director		5. Social Security Number 6. Sex 10 M 2 F 7. Age (In yrs. last birthday) 11 Under 1 Year 11 Under 24 Hrs. When the desired of Decedent Security Number 12 Hrs. When the desired of Decedent Security Number 1 Year When the desired of Decedent Security Number 1 Year To Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. When the desired of Decedent Security Number 1 Year When the desired of Decedent Security Number 2 Hrs. The desired of Deceden		9. Birth 949 MAR	place (State or Foreign intry)
	yland 10W		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Be-f st	Director	HARYland WA BAILIMERE			1 X Yes 2 □ No
	with th			10g	. Citizen of What Co.	intry?
	ms 23	Funeral	2202 HC Cullogh SHEFT 2/2/7 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puer Puer In U.S.)	Specify Yes or No-	14. Race - Amer	
39	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If itam 27 is marked other than "natural", or itams 23s or 28e-f show or other traumetic event, the Preficel Ever it art must be modified at	by Fur	Armed Forces? If Yes, specify Cuban, Mexican, Puel 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify: Year or Dates:	rto Rican, etc.)	Black, White	1
5-0036	72 hou	eted	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of wo	orking 16	b. Kind of Business/I	HMSC(CAK)
21	within and the state of the sta	Completed	Elementary/Secondary (0-12) College (1-4or 5+) College (1-4or 5+)	1	Both of x	lan stast
d 21	filed with Hygiene other thai			me (First, Middle, Mai	iden Sumame)	JM -0726/
ylan	nould be d Mental narked c	To Be		Cotheein	E Stanle	E C
Mary	d 2 sho h and 7 is mu traum		19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Fi	2 .1.	m 1 .	p Code)
-	s 1 and f Health itam 27 other tr		20a. Method of Disposition 20b. Place of Disposition (Name of cemetary, crematory or other place)	Date 200	c. Location - City or T	own, State
ШO	Pages nent of ant: If it		'4 Donation 5 Other (Specify)	904 E		Makyland
Baltimore	permit. Pag Deportment Important: I any injury o		21. Si nature of Funeral Service Licensee 22/ Name and Address of Facility	e Funera	Sexuich	whend 21,28
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, expean failure. List only one cause on each line.			Approximate Interval Between
£	Physician	Si (Immediate Cause (Final disease or condition Apric Enchalor the			Onset and Death
	/Medical Examiner		resulting in death) ue to (or as a conse wence of):			4 days
		ner	Sequentially list conditions, if any locating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events b. Due (or as a consequence of): Aut Pespiratory b. Due (or as a consequence of): Cause (Disease or injury that initiated events)		,	-
	lificate be executed g physicien and as the burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	s Synd	Rome	5 days
68760,	sicien buria		d d	1	MINER	•
	rtificate ng phy as the	Aedical	In France	RÔVES DY MEDICAL EXA	THE STATE OF THE S	
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physiclan/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnance FIFE 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		23d. Date of deliv Month	ery Day Year
Ω.	s that t ned by e deta	by Ph	Part I. Differ significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	co use contribute to t	he cause of death?
ord	w requires to been signer should be	ted t	Chronic Substance House	1 ☐ Yes	2No 3□ Prol	pably 4 □Unknown
Records,	e law r has be je 2 sh	Completed	MAINUtrition	24a. Was an autopsy performed	prior to co	opsy findings available impletion of cause of
Vital F	in: Th		25. Was case referred to medical 26. Place of De	1 ☐ Yes 2€ ath (Check only one)		2□ No
f Vi	Physicien: r this certifica ral director, p	To Be	examiner?	Home 5 Residence	a 6 ☐Other (Speci	(y)
n of	ding Physicien: The lav n. After this certificate has funeral director, page 2		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28c. Injury at Work?	28d. Describe how i		
Division	eatler:	ficat	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Stree	t and Number or Rura	al Route Number
Ö	s after s after el Dire	Certification;	4 Homicide determined building, etc. (Specify)	City or Town, S	tate)	
	To the Hospitel or Ati within 24 hours after d To the Funerel Direct completely filled in by	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place of the control	e, and due to the causurred at the time, date	e(s) and manner as s and place, and due t	stated. the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	29d.	Date signed (Month,	Pay, Year)
	N/)		4. Near Kando MD DZ7163	1	0/28/	04
	7 (1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	UNTE	24 LAN	0 Stool
(Sta	te	31. Date filed (Most). Gal 32. Desiderar's Signature	West 1	= 10 1(1000	777
	Registr	ar	001204 7			

State of Maryland / Department of Health and Mental Hygier 0 0 1. 34439 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Mary 2:20P^M Marsh October 26 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 12623 Shell Mill Rd. Worchester Bishopville If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 218-26-3178 Director England 04 1907 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours atter death with the Maryland nent of Health and Mental Hygiene. nt: If item 27 is marked other than "natural; or Items 23e or 28a-f show ral, or Items 23e or 28a-f show Examiner out the notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Glen Burnie Director Maryland Anne Arundel 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14 Marley Neck Road 21060 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ☐Yes 2 No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Specify 3 X Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Household 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be С. James Frskine Florence George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a t: If item 27 is or other treu James Marsh (son) 12623 Shell Mill Road, Bishopville, MD 21813 Date 30 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Oct. 1 X Burial 2 Cremation 3 Removal from State permit. Page Department of Importent: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Crestlawn Cemetery 2004 Baltimore, Maryland rvio Licens 21. Signature of Funeral Se Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician P 00 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any, leading to initial cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Examiner Dualty for as a consequency of The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) Yes P.0. 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 3 Probably 4 □Unknown 1 ☐ Yes 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No of Vital 1 ☐ Yes or Attending Physician; 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence State (Specify) ons Kess Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division Natural 2 Accident 5 Pending investigation atter death Director: in by the Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours att To the Funeral Di completely filled in 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ro the 29b. Signature and title of certifier 30. Name and address of person who completed cause of eath (Item 23a) (Type, Print) 5 Aquahar T Road Glea Bunie no 2161 Redyer 507 040 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			1 - For State Ragistrar	State of M	Maryland / Dep Ce	artment of I	Health and M Death	Mental Hygier	2004	34440
			Decedent's Name (First, Middle	, Last)				2. Date of Death	T.	3. Time of Death
	Physic /Medi		Elsie	Louise	McMaha	n		1	Day Yéar 25. 200	14 4 : 0101E M
	Exami		4a. Facility Name (If not institution, Saint Josep	, give street and number	r)		or Location of Death		c. County of Dea	
	Funeral Director		217-24-5150	6. Sex 7. A	Age (In yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Yea 1/28/192	(r) C	thplace (State or Foreign ountry) rth Carolina
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	the Mary 28a-f sh cotified	ector	Maryland Balti	more	Middle Ri	Ver		100	Citizen of What C	1 □ Yes 2 🕍 No
	3a or	ä		2 3 2 2	a		0			ountry?
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Itam 27 is marked other than "natural", or itams 23s or 28s-f show other traumatic event, the Medical Exercited rives be notified at	by Funeral Director	208 Middleway F 11. Marital Status 1 Never Married 2 Marrie 3 Xidowed 4 Divorced	12. Was Deceden Armed Forces	nt Ever in U.S. 13. 2. XNo	21 220 Was Decedent of lif Yes, specify Cub 1 □ Yes ※□ No	Hispanic Origin? (Spoan, Mexican, Puerto	ecity Yes or No-	S. A. 14. Race - Am. Black, Whi	te, etc.
2-0	72 hou	ted	15. Decedent	's Education	16a. Dece	dent's Usual Occu	pation	16b.	Kind of Business	White /Industry
21215-0036	permit. Pages 1 and 2 should be filed within 7 Deperfiment of Health and Mental Hygiene. Important: If itam 27 is marked other than "rany njury or other traumatic avant, "tru Med 2006.	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or	r 5+) life.	naker	during most of work ad)		vn Home	
	al Hyg I othe vant,	BeC	17. Father's Name (First, Middle, L	.ast)	110110	ILLIANCE	18. Mother's Name	e (First, Middle, Maide		
ylaı	Menta Menta arkad aric a	To	Tom Bolick					Unknown)		
Maryland	l 2 short and raum		19a. Informant's Name/Relationsh					al Route Number, City		
	1 and Healtl am 27		Shirley Jean Ar 20a. Method of Disposition	itrim (Daugh	nter) 214]	Beech Vie		Towson, Ma	eryland . Location - City or	
nor	ages ant of it: If it		1 X Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp		e cemetery, crei	natory or other pla	ice)	10/28		
Baltimore,	oertme cortan		21. Signature of Funeral Service L		22	. Name and Addre	Cemetery ess of Facility	2004 Gar	rison F	orest, MD
m	Depermine Deperm		Michael (2. Sall	20 50 B	cuzdzinsk 407 Old R	ki Funeral Pastern Av	Home PA enue Esse	x. Marv	land 21221
	Physician		23a. Part1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final	complications may cause only one cause on each	ed the death. Do not ent line.	er the mode of dyi	ng, such as cardiac o	or respiratory arrest,	/ ··································	Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	aDue to (or a	s a consequence of):					_Days
	Examiner		Sequentially list conditions,	b. Sepsi	5					Days
	ed sit	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequence of):					
, 0	cate be executed oblysician and the burial-transit	i Examiner	that initiated events resulting in death) Last	c Due to (or a	s a consequence of):					
8760,	cate b physic the b	dicai		d						
O. Box 6	The law requires that the death certificate has been signed by the attending tage? Should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 gronths? 1 □ Yes 2 ⊠ No 9 □ Unknows		2 Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of del Month	ivery Day Year
Vital Records, P.O	juires that I n signed by Ild be deta	by	Part II. Other significant condition Metastatic Sr			nderlying cause giv	ven in Part I.	23e. Did tobacco		the cause of death?
S	aw requ s been 2 shoul	Completed						24a. Was an	24b. Were au	Itopsy findings available
R	The law ate has page 2	mo						autopsy performed? 1 ☐ Yes 2 🔼 N	prior to	completion of cause of
/ita	ician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?				26. Place of Death		0 1 1 1 1 1 0 3	2,00
of V	Physician: this certific ral director.	၉	1 ☐ Yes 2 No	Hospital: 1 Inpat		t 3□ DOA Ott	ner: 4 Nursing Hor	ne 5 Residence	6 □Other (Spe	cify)
	fter fter	Certification:	27. Manner of D ath 1 Natural 5 Pending 2 Accident investiga	ation	ay Year) 28b. Time of Injury	28c. Injui Woi M 1 □	ryat rk? ∣Yes 2 □No	28d. Describe how inju	ury occurred	
Division	tal or Attendii is after death. al Director: A ed in by the fu	ertific	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ned 286. Place of In	njury - At home, farm, str etc. <i>(Specify)</i>	eet, factory, office	2	28f. Location (Street a City or Town, Stat		ral Route Number,
	To the Hospital or Att within 24 hours after de To the Funeral Direct completely filled in by t	edical (29a. Certifier (Check only one)	Physician: To the best xaminer: On the basis of and manner s	t of my knowledge, death of examination and/or inv	occurred at the tire restigation, in my o	me, date and place, a opinion, death occurre	and due to the cause(sed at the time, date an	s) and manner as nd place, and due	stated. to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier			29c. Licens	se number	29d. Da	ate signed (Monti	n, Day, Year)
			> exaginan	" moelle	e m.0	D 4	1410	Oct	ober 25	th, 20ry.
	1		30. Name and address of person w	no completed cause of	death (Item 23a) (Type,		e en "les"		*	1
			31. Date filed (Month, Day, Year)	a, M.D.	76-21 051 (er Driv	e Towson	, Maryla	nd 2120	14
	Sta Registr		OCT 2 9 20		- /	Sparks	/	£		

Physician	_			Ce	rtificate	of L	Death		lental Hyg	eg. No.	004	3444
	ì	Jennifer Bryant	•						2. Date of Dea Month	th Day	Year	3. Time of Death
/Medical Examiner		a. Facility Name (If not institution, give			4b. City, To	WD Or	Location	of Death	actober	22	ZCO4 unty of Death	19:45 64
Examiner	-	7 ()	soital C	رجادر	P	مام	10	Dodui			Hino	
Funeral Director		245-06-5298		(In yrs. last birthday) 39 Yrs.		Year	If Under a	24 Hrs. Min.	8. Date of Birth	1		place (State or Foreig
and		Jsual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation							10d. Inside City Limits
with the Maryl to 28e-f sho		MD Baltim	ore	Roseda								1 ☐ Yes 2 🕅 No
death with the Maryland ms 23a or 28e-f show ms to rediffed at neral Director	1	20 Tameron Plac	e		10f. Zip C	ode L237	,		1	-	of What Cou	ntry?
, a 2 3 5	2	1. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 XN If Yes, Give Year or Dates:	lo	Was Deceder If Yes, specify 1 ☐ Yes 22	_	spanic Orig , Mexican Specify:	gin? (Spe , Puerto I	cify Yes or No- Rican, etc.)		Race - Ameri Black, White ecify: TaTh	etc.
Maryiand 21215-UU36 Id 2 should be filed within 72 hours af th and Mantal Hygiene. 27 Is marked other than "natural", or treumatic event, the Medical Evan. To Be Completed by F		15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	lication de completed) College (1-4or 5	(Give	dent's Usual (kind of work DO NOT use	done du	ırina most	of workir	ng	16b. Kind o	of Business/Ir	ndustry
Ne the the Con		Elementary/Secondary (0-12)	0`	Maryla	and Ste		Inspe			Cor	struct	ion
Maryland 21213 12 should be filed within 12 should be filed within 7 is marked other than "I redumatic event, the Meet To Be Comple		7. Father's Name (First, Middle, Last) Mack Bryant							(First, Middle, M Royall		name)	
lore, Maryis ges 1 and 2 should tof Health and Mer If item 27 is marke or other treumatic		19a. Informant's Name/Relationship σ harles J. Most/Bro			ndy Ma				l Route Number,	City or To	wn, State, Zij	Code)
Saltimore, IN emil. Pages 1 and 2 Pepartment of Health mportent: If item 27 i iny injury or other tre DICE.	-	0a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify,	Removal from State	20b. Place of Disponsion Commetery, crem	sition (Name natory or othe	of er place,	, !	D	ate 7/2004		on - City or To	own, State
Baltimory permit. Pages ' Department of H Importent: If ite any injury or ot once.	2	21. Signature of Funeral Service Licens		22	. Name and	Address	of Facility	Cva	ach/Rose	dale	Funera	1. Home
Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	a. Esopha	θ.	iceal				r respiratory arre	est,		Approximate Interval Between Onset and Death
Examiner	S il	Sequentially list conditions, I any, leading to immediate success. Enter underlying cause (Disease or injury hat initiated events	b Due to (or as a	consequence of):								
por rou, icate be executed physician and s the burial-transit	r	hat initiated events esulting in death) Last	Due to (or as a	consequence of):							-	
the death certification of the attending ched for use an investment in ysician/Me	11 2	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 DNo 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 24 □ Pregnant at 19 □ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregr Other (speci					1.0	Date of delive	ery Day Year
quires that n signed by lid be deta	۱,	art II. Other significant conditions co	ntributing to death bu	t not resulting in the ur	iderlying caus	e given	in Part I.			acco use c		ne cause of death?
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ding Phys n. After this funeral dii	+	5. Was case referred to medical examiner? 1	lospital: 1 Anpatier 28a. Date of Injury (Month, Day	28b. Time of		Other: Injury a Work?	4□ Nurs	sing Hom	(Check only one e 5 Resider Bd. Describe how	nce 6 🗆 (()
To the Hospitel or Attending F within 24 hours alter death. To the Funeral Director: Affar I completely filled in by the funeral Medical Certification;		3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc.	ry - At home, farm, stre (Specify)	eet, factory, of			-	Bf. Location (Str. City or Town,	eet and Nu State)	mber or Rura	l Route Number,
To the Hospitel or within 24 hours afte within 24 hours afte completely filled in I Medical Cert	2	9a. Certifier (Check only one) Sertifying Physical (Check only one)	sicien: To the best of ner: On the basis of and manner stat	f my knowledge, death examination and/or inved.	occurred at the estigation, in	he time, my opin	, date and nion, death	place, ar	nd due to the car d at the time, da	use(s) and te and plac	manner as st	ated. the cause(s)
To th withir To th comp	2	9b. Signature and title of certifier	0/	MA	29c. Li	cense r	number				ned (Month,	
11	3	0. Name and address of person who co	empleted cause of de	ath (Item 23a) (Type, F	Print)	2	VT.	フン	Hinore,	CTOB	er dd	8004
State		2c Orastasics Sal 1. Date filed (Month, Day, Year) OCT 2 9 2004	32. Registral	S Frenklin	Squar	e]	Drive	Ba	Hinore,	Menzy	land 2	1237

DHMH 17 Rev 1/2001

Bryant-Most, Jennifer

			1 - For State Registrer	State of Mary	/land / Depa <i>Cel</i>	artment of I	lealth and Death		2 € 0 0 1	4 3	4442
	Physici /Medi		1. Decedent's Name (First, Middle, La William F. Mulli	lgan Jr				2. Date of Death Month October	Day	Year 004	3. Time of Death 1:25 AM M
ı	Examir	er	4a. Facility Name (If not institution, giv Washington Adver	ntist Hospit		Tako	or Location of Death oma Park		4c. County Montg	of Death gomery	7
	Funeral Director		5. Social Security Number 6. S 027-24-5211 1 Usual Residence of Decedent	C7 C -	n yrs. last birthday) 1 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) May 15,	(ear) 1933	9. Birthpla Country Conne	ce (State or Foreign y) Cticut
	d within 72 hours after death with the Maryland Jiene. r than "natural", or items 23a or 28e-f show If a Medical Examinat must be notified at	Funeral Director	10a. State 10b. County	e George's	oc. City, Town or Lo Hyatts	Ville 10f. Zip Code)783	10(g. Citizen of W	Vhat Country	d. Inside City Limits 1 ☐ Yes 2 ☑ No y?
215-0036	hours after des tural', or items al Examinar m	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced		50-53	1 ☐ Yes 2 🏋 No			14. Race Black Specify:	- Americar k, White, etc	e.
N	filed within 72 Hygiene. Ither than "nai	Completed	15. Decedent's Et (Specify only highest gra Elementary/Secondary (0-12) 12	College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire .ntenance	during most of wor d)	rking 16	Sb. Kind of Bu		stry
yland	ed al	To Be	17. Father's Name (First, Middle, Last)			unk		ne (First, Middle, Ma			unk
Баптоге, маг	t, Pages 1 and 2 rtment of Health a rtant: If item 27 is njury or other tra		Steve Silliman/fi 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 ☒ Other (Specify 21. Stituture of Funeral Service Licen	riend Removal from State	1401 Ob. Place of Dispo cemetery, cren	N Street	: NW #608	Washing Date		200	105
	Physician		21. Signature of Funeral Service Licen Rona La S 23a. Pan 1. Enter the disease, or companded to the shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the one cause on each line.	Ba	ate Anat Itimore, er the mode of dyin	omy Board MD 2120 ng, such as cardiac	,	3altimo	A	pproximate pproximate psterval Between pset and Death
9,00,	physician and burial-transit	dicai Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate dause. Et et ut Jarrying Cause (Disease or injury that intitated events resulting in death) Last	Due to (or as a co Due to (or as a co C. Due to (or as a co d.	nsequence of):						
O. Box a	certif iding ise a	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Mont	of delivery th Da	ay Year
ecords, r	The law requires that the death at be has been signed by the atter page 2 should be detached for u	by P	Part II. Other significant conditions of								cause of death?
	in: The law re ificate has be or, page 2 sho	e Completed	FIBALLATION 25. Was case referred to medical			,		24a. Was an autopsy performer	d? de	ior to compleath?	findings available letion of cause of
VISION OF VI	To the Hospital or Attending Physician: The law within 24 butus after death. To the Funeral Director: Atten this certificate has completely filled in by the funeral director, page 2	ation: To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Time of	28c. Injun World	er: 4 🗆 Nursing Ho	th (Check only one) ome 5 Residence 28d. Describe how			
2	oital or Atte ars after de ral Directo lled in by th	Certification;	3 Suicide 6 Could not be determined	building, etc. (S)	pecify)			28f. Location (Stree City or Town, S	State)		
	To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by	Medical	29a. Certifier (Check only one) 1 ★ Certifying Phyone 1 ★ Medical Example 29b. Signature and title of certifier	ysician: To the best of my liner: On the basis of exal and manner stated.	y knowledge, death mination and/or inv	occurred at the tin estigation, in my of	oinion, death occur	red at the time, date	se(s) and mana and place, an	nd due to the	e cause(s)
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	Registr		OCT 2 9 200		a B	Sparks	/				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 004 34443 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 27 200+ Month 515 **Physician** FLORENCE MONAGHAN OCTOBEZ. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE City BALTITORE GOOD SAMPRITAN HOSPITAL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕱 F Director 218-14-0806 80 5/12/1924 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City Town or Location 10d Inside City Limits 28e-f ehow other treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD BALTIMORE TOWSON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a 8212 PLEASANT PLAINS ROAD 21286 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian Black, White, etc. 1 ☐ Yes 2 ☐XNo If Yes, Give filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XVo by Specify: Specify: 3 Widowed 4 Divorced WHITE Year or Dates "naturel", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other treumetic avent Elementary/Secondary (0-12) College (1-4or 5+) STATE OF MARYLAND ACCOUNTING CLERK 12TH GRADE

17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be LAURENCE A. MCHUGH ၉ ROSE SPARTANA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN C. MONAGHAN HUSBAND 8212 PLEASANT PLAINS ROAD TOWSON, MD 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State GARRISON FOREST VET. * 4 ☐ Donation 5 ☐ Other (Specify) 11/3/2004 OWINGS MILLS. MD 2 CEMPTERY ess of Facility 21. Signatury of Funeral Service Licensee THE JOHNSON FUNERAL HOME, P.A. TOWSON, MD 8521 LOCH RAVEN BLVD. part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each(line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician ARRHYTHMIA disease or condition resulting in death) 5 MINUTES /Medical Due to (or as a consequence of) Examiner 1 HOUR MYOCHEDIM INFARCTION Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine be executed burial-transit 10 YEARS - DERTENSION Due to (or as a consequence of) P.O. Box 68760. the attending physicien Physician/Medical death certificate as the IF FEMALE esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 No detached 9 Unknown 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has autopsy performed? 2 No 1 Yes director, 25. Was case referred to medical 26. Place of Death (Check only one, examiner' Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1t Yes 2 □ No 2 ER/Outpatient 3 DOA this funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) • Hospitel or Attending Pl 24 hours after death. • Funerel Director: After the 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending Injury 1 Natural 1 🗀 Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospitel of within 24 hours of To the Funerel D 29a. Certifier 1 KG Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MIN 00000 EZ 27, 7004 D30950 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)
(CHAN KOSTOUS AT HID, GOOD SATARTAN) HOSPITAR 5601 LOCH PANEW BOLLEVARS, BANTIMORE, MA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2004

	Certificate of Death	Reg. N	
Physician	Decedent's Name (First, Middle, Last)	2. Dete of Deeth Month	3. Time of Death
/Medical	Gould Osgood Machitire	October 2	26, 2004 4:00 AM
Examiner	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		c. County of Death
	307 FOLUS LAIR	erdeen	Harford
Funeral Director	212-01-8443 1 M 2 F 94 Yrs. Months Days Hours	Min. (Month, Day, Yee	
	Usuel Residence of Decedent	June 19,	1910 Delaware
rylan	10a. Stete 10b. County 10c. City, Town or Location		10d. Inside City Limits
Ba-fa	Maryland Harford Aberdeen		1 ☐ Yes 2% No
vith the Mar or 28a-fs be notified	10e. Street end Number 10f. Zip Code		Citizen of What Country?
er death with the Marylan teme 23s or 28s-f show her must be notified at unnersi Director			USA
ifter death virter death virter must	11. Marital Status 12. Was Decedent Ever in U,S. 13. Was Decedent of Hispanic O If Yes, specify Cuban, Mexic. 1 □ Never Married 2 □ Married 1 □ ∑s 2 □ No	an, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
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d 2 st th and 7 te n traur	19a. Informant's Name/Relationship (Type, Print)19b. Mailing Address (Street and NumiMarc D. Macintire / Son307 Fords Lane, 1		
Heal Heal tem 2	20a Method of Disposition 20b. Place of Disposition (Name of		Location - City or Town, State
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The Medical Examiner must be notified at once. To Be Completed by Funeral Director	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Spesutia Cemetery	10-30-04 P	Perryman, Maryland
ortar	21. Signature of Euneral Service Licensee 22. Name and Address of Each	litv	CITYRUITY TAITY ISSUE
Depa Impo any in	McComas Funera		on, Maryland 21009
HARRISH IN	23a. Part . E ter the disease, or complications that caused the death. Do not enter the mode of dying, such a shock, or heart failure. List only are cause on each line.		Approximate Interval Between
Physician	Shock, or heart failure. List only the cause on each line.		Onset and Death
/Medical Examiner	Immediate Cause (Final disease or condition	failure	1 month
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ifficate be executed g physician and as the burial-transit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es a consequence of):		
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	resulting in death) Last		
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at the death cert d by the attendin letached for use Physician/N	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert	I. 23b. Did tobacc	o use contribute to the cause of death?
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signe bed			Odb Warrandow Gadina
requ		24a. Was an auto performed?	opsy 24b. Were autopsy findings available prior to completion of cause
The law require sate has been single 2 should Completed		Value 2001 - W	of death?
icate	A OS Was area of conditional and conditional a		1 Yes 2 No
sician certifi irector	examiner?	ursing Home 5 Presidence	6 DOther (Specific)
y Physic eral dire	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe how inj	
ath. r: Afte	1 ☐ Matural 5 ☐ Pending (Month, Dey Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐]No	
r Atte	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street a City or Town, Sta.	and Number or Rural Route Number, te)
To the Hospital or Attending Physician: The law requires that the death certwith 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendincompletely filled in by the funeral director, page 2 should be detached for use Medical Certification: To Be Completed by Physician/N			
Hosp 24 hor Fune fical	29a. Certifier (Check only one) 1 United State Inc. To the best of my knowledge, death occurred at the time, date a (Check only one) 1 United Inc. To the basis of exemination end/or investigation, in my opinion, de and manner stated.	nd place, and due to the cause(ath occurred at the time, date ar	s) and manner as stated. nd place, and due to the cause(s)
ithin 2 or the or the omple	one) and manner stated. 29b. Signature and title of certifier 29c. License number	29d. D	ate signed (Month, Day, Yeer)
F ≯ F 8	1870 MD D0036		0/26/2004
(X)	30. Name end address of person who completed cause of death (Item 23a) (Type, Print)		BELDIR MD.
12.	SHERIF OSMAN 520 UPPER	CHESAPE	AME OR.
State	31. Date filed (Month, Day, Year) 32. Registrer's Signature		,,,,
Registrar	OCT 2 9 2004 Show & Spark		

DHMH 16 Rev 6/95

MacIntire

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2004 34445 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Billy Bob 5:50 AMM Pryor October 23. 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Leonardtown

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yeer)
| Adopths | Days | Hours | Min. | July 22, 1 St. Mary's Hospital St. Mary's Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1XM 2□F 1932 Missouri 566-34-4442 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 【No Virginia Shenandoah Strasburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22657 145 Hailey Lane <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disabled 11 Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Harrison Pryor Pauline Myer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 145 Hailey Lane #F1 Strasburg, VA 22657 Mary Ellen Pryor/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State ' 4 ☐ Donation, 5 ☐ Other (Specify) Alexandria, VA Metropolitan Crematory 10/23/04 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Dellinger Funeral Home Men 40,00 157 N. Main St., Woodstock, VA 22064 23a. P. 1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate C-use (Final disease or condition resulting in death) ue to (or as a consequence of): Ha Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence -050NGL Due to (or as a consequence of): IF FFMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform rmed? 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Proutpatient 3 DOA 27. Mann-un Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 29a, Certifier 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2914CCO 10-23.04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hosp. W. Congray Mahr 17 M-cha

State Registrar

Physician

/Medical

Examiner

Funeral

Director

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or items

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Interest Inforciant: if Item 27 is marked other than "natural", or Item important: if Item 27 is marked other than "natural", or Item April 1910 or other traumatic event, Item Medical Exerting and.

Physician /Medical

Examiner

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filled in by the funeral

To the Hospital or Attending Physician:

attending physician

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

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32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygien 2004 1 - For State Registrar 34446 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** HEODORE 4:50 AM 2004 /Medical OCTOBER 27 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HARBOR HOSPITAL CENTER BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan. 29 N/A5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 100 M 2□ F Yrs. Director 174-34-3222 59 Jan. PA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "naturel", or Items 23a or 28a-f show ury or other traumatic event. The Medical Examinar must be notified at ury or other traumatic event. The Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Be Completed by Funeral Director 1 ☐ Yes 2 X No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1423 Thies Drive 21122 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 IXYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 National Security Agency US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Theodore S. Pyle Rose 0ddo Mary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carol L. Pyle 1423 Thies Drive, Pasadena, MD 21122 (spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Oct. 30 2004 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. `4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery Baltimore, Maryland e of Figneral 22. Name and Address of Facility Stallings, Funeral Home, P.A. Pasadena, MD 21122 3111 Mountain Rd., 23a. Part1. Enter the disease, or complications that can shock, or heart failure. List only one cause on ear sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Priysician Acute Rena disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SEPSIS Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit B1000 GASTROENTESTINAL Due to (or as a consequence of): Box 68760. the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death Year 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, ENCEPHALOPATHY Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Thknown ARTERIAL 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 202 No 2 1 No 1 ☐ Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After 1 HNatural 5 Pending death. nours after death.

nerel Director: A
filled in by the fu 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours at To the Funerel D completely filled i the certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 RESOOO OCTOBER, 27, 2004 MD ISSA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EYOB 21225 3001 BALTIMORE S HANDVER ST MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 2 9 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 26 **Physician** 321 Octuber 200 /Medical 4a. Fecility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death JOhn. Social Security Number (In yrs. last birthday If Under 24 Hrs Funeral 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days 1 X M 2 □ F Hours Min 67 Director Yrs 216 32 1419 July 20,1937 Maryland Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 27 is marked other then "naturel", or Items 23a or 28e-f show traumatic event, the Medical Examinar must be a citiful at 10d. Inside City Limits Maryland Baltimore Directo Middle River 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12912 Community Drive 21220 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after Department of Healith and Mental Hygiene. Importent: If item 27 is marked other then "naturel; or Item any finury or other traumatic event, the Machael Evan many injury or other traumatic event, the Machael Evan many injury or other traumatic event, the Machael Evan many injury or other traumatic event, the Machael Evan many injury or other traumatic event, the Machael Evan many injury or other traumatic event, the Machael Evan many injury or other traumatic event, the Machael Evan many injury or other traumatic event, the Machael Evan many injury or other traumatic event, the Machael Evan many injury or other traumatic event. Black, White, etc. 1 Never Married 2 Married 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Grocery Store Owner/Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles L. Plowman Sr. Emma Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2221 Westridge Rd. Timonium, Md. 21093 Terri Stowars (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Bayview Crematory 10/29/2004 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shack, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Mrcmbotic Physician Litar /Medical Que to (or as a consequence of): Examiner lo months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (of as a consequence of): certificate be executed burial-transit Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of): physician Physician/Medical as the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐ Pregnant at time of death 5 Dother (specify) the detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? by 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has page 2 autopsy performed? certificate Yes 2 No To the Hospitel or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No 2 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification; 28c. Injury at Work? After 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending death. investigation M 1 Yes 2 No after deatl Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a pellij Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Octobe 26, 2004 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Troy 21287 600 N. WEIR St. Petrich. 31. Date filed (Month, OCT 2 9 2004 32 Registrar's Signature State Registrar

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Baltimore,	Pages 1 nent of H ant: If ite ary or ot		20a. Method of Disposition 1 Burial 2 ☐ Cremation	3 □Removal from Sta	ate ceme	etery, cren	sition (Name of natory or other plac	, 1	Date	20c. Location	-	
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VITAI	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		_	Othe	A	eath (Check only o			
Ö		. To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of I		Outpatient b. Time of	3 DOA Othe	4 [] Nursing	Home 5 Resid			
ם י	Attending in death. ector: After by the funer	tion	1.XNatural 5 Pendin 2 Accident investig	g (Month,	Day Year)	Injury	Work	Yes 2 □ No	28d. Describe	iow injury occi	irrea	
DIVISION	Atter	ertification;	3 Suicide 6 Could r	not be 28e. Place of	Injury - At home,	, farm, stre			28f. Location (5	Street and Nurr	ber or Rural	Route Number,
5	s after or s after or	Cert	4 Homicide	building,	etc. (Specify)		•		City or Tox			
	hour hour uner		29a. Certifier 1 Certifyin	g Physician: To the be	est of my knowled	dge, death	occurred at the tim	ne, date and pla	ce, and due to the	cause(s) and n	nanner as sta	ted.
	I o the Hospitel or Attendi within 24 hours after death. To the Funeral Director; A completely filled in by the fu	fedical	one)	and manner	s or examination	and/or inv	estigation, in my of	oinion, death oc	curred at the time,	date and place	, and due to t	he cause(s)
1	To	Σ	29b. Signature and title of certifier		mn		29c. License			29d. Date sign	ed (Month, D	ay, Year)
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	7			who completed cause of				Balton			_	
	Sta	te	Jessica Hershen. 31. Date filed (Month, Day, Year)	32. Regi	istrar's Signature	1190	1001+	Lunin	iore MD	2120	7	
	Registra		QCT 2 9 20		م س	9	land.					

	i	1 - For State Registrar	State of Maryland	/ Depar	tment of Health	and Mer	ntal Hygie	2004	34450
Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last) 4a. Facility Name (If not institution, give st MARY/AND 76	1/EY reet and number) neral Hosp.	ital	4b. City, Town, or Location Bal time	n of Death	Date of Death Month CFODER	4c. County of Deat	3. Time of Death
Funeral Director		5. Social Security Number 6. Sex 214 18 0667 1□	7. Age (In yrs. last			ar 24 Hrs o	Date of Birth (Month, Day, Y UL. 9, 1	N/A _{9. Birt} 916 VIR	hplace (State or Foreign unity) GINIA
Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD • N/A		own or Loca					10d. Inside City Limits 1 Yes 2 □ No
h with the	al Director	10e. Street and Number 813 E. PRESTON	STREET		10f. Zip Code 21202			J.S. OF	
urs after deat al', or Items?	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		as Decedent of Hispanic Cres, specify Cuban, Mexico		Yes or No- an, etc.)	14. Race - Ame Black, White Specify: B	
is 1 and 2 should be filled within 72 hours after death with the Maryland of Helelin and Meantal Hygiene. If Helelin and Meantal Hygiene. Other traumatic event, it a Mealical Examiner must be notified at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12TH	College (1-4or 5+)	6a. Deceder (Give kii life. DC WAITR	nt's Usual Occupation nd of work done during mo O NOT use retired)	ost of working		b. Kind of Business	,
and Mental Hygiene. 2 should be flied with and Mental Hygiene. Is marked other than aumatic event, Italia	To Be C	17. Father's Name (First, Middle, Last)	CEASED)				irst, Middle, Ma	iden Sumame) CE (DEC)	EASED)
2 should be and Mental Is marked c	Ĕ	19a. Informant's Name/Relationship (Typ	e, Print)		Address (Street and Num	ber or Rural R	oute Number, (
permit. Pages 1 and 2. Department of Heelth at Important: If Item 27 is eny injury or other tracents.		DELORES PLOWDED 20a. Method of Disposition	20b. Plac	813 E	PRESTON ion (Name of story or other place)	STREE		TIMORE , I c. Location - City or	
Pages 1 Iment of He tant: If Iter		1 Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	WOO!	DLAWN	CEMETERY		04 BA	LTIMORE	, MARYLAND
Departit Departiment Imported once.		21. Signatura uneral Serviculo nse	WIS TO GWYN	N LE 451	_	YNN FU	NERAL		1215-6393 ,,MD.
		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	6.1	Do not enter		as cardiac or re	espiratory arres	. DALIO	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequent			<u> </u>			
Examiner	er	Sequentially list conditions, b.	Due to (or as a consequen	ice of					
be executed iicien and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	B 1- /						
0 50	cal E	d.	Due to (or as a consequen	ice oi).					
To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours effer death. To the Funeral Director: Affer this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ic. If yes, outcome of pregnancy 1 \(\text{Live birth} 2 \text{ Fetal de} 4 \(\text{Pregnant at time of death} \) 9 \(\text{Unknown} \)	ath 3□E	ctopic pregnancy Other (specify)			23d. Date of deli	very Day Year
gned by	by Ph	Part II. Other significant conditions conf	ributing to death but not resulting	ng in the und	erlying cause given in Par	t I.		cco use contribute to	. 1
w require been si should t		HUDERTE 11510	Acthri	418	(3)		1 ☐ Yes 24a. Was an	2 No 3 Pr	topsy findings available
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ding Physician: The lar h. After this certificate has funeral director, page 2	tion; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		/Outpatient Bb. Time of Injury	Other	Nursing Home 28d		ce 6 Other (Specinjury occurred	cify)
or Atten fter deat frector: n by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stree	t, factory, office	28f.	Location (Stree City or Town,	et and Number or Ru State)	ral Route Number,
To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the tu	edical Ce		ician: To the best of my knowle er: On the basis of examination and manner stated.						
To the To the To the Complex c	Me	29b. Signature and title of certifier	-		29c. License number	r / 3	29d	Date signed (Month	n, Day, Year)
K		30. Name and address of person who con	ppleted cause of death (Item 23	3a) (Type, Pr	aryland			11.	11
1		Maylik Bhal 31. Date filed (Month, Day, Year)	ani, m. D. 9	0/11	aryland	Gen	eral	HOSPi	Tal
Sta Registi		OCT 2 9 200	14 Merces D	× do	cole				

			1 - For State Registrar	State of Marylan	-	artment of H			iene 004	34451
			Decedent's Name (First, Middle	, Last)				2. Date of Dea	th	3. Time of Death
	Physici		Sun G	ROWAN)			Month	Day Year	W 9:15 AM
	/Medic		4a. Facility Name (If not institution		,	4b. City. Town, or	r Location of Deat	h	4c. County of Oeat	
4	Examin	er	1) . (- 11	PITAL	(-180	1 13.00	1115	ANDE	ARUNDEL
			5. Social Security Number	6. Sex 7. Age (In yrs.		If Under 1 Year	If Under 24 Hrs		9. Birt	hplace (State or Foreign
	Funeral Director		219-16-8869	1□M XXX 80	Yrs.	Months Days	Hours Min.	(Month, Day Aug • 2	25, 1924 Co	untry) MD
			Usual Residence of Decedent			1				
	/land		10a. State 10b. County	10c, Cit	y, Town or Lo	cation				10d. Inside City Limits
	Man, 1 sh	ţō	MD	Anne Arundel			Glen	Burnie,	MD	1 □Yes 25No
	1 the	rec	10e. Street and Number 302 Norman	_		10f. Zip Code	21.00		0g. Citizen of What Co	*
	72 hours after death with the Maryland natural', or itams 23a or 28a-f show Jisal Exandrat must be rediffed at		302 Norman	Avenue			2106	0	U.S.A	١.
	ms 2	era	11. Marital Status	12. Was Decedent Ever in U.	.S. 13.	Was Decedent of H	ispanic Origin? (S	specify Yes or No-	14. Race - Ame	
(0	r ita	Fur	1 Never Married 2 Marr	Armed Forces? ned 1 ☐ Yes 2 🛣 No		f Yes, specify Cuba		to rican, etc.)	Black, White	White
21215-0036	urs a	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2] ∏ No	Specify:		Specify:	WIIICE
2-0	72 ho	ted	15. Decedent (Specify only highes	t's Education	16a. Dece	dent's Usual Occupa	ation during most of wo	rkina	16b. Kind of Business/	Industry
21	within ene.	Jple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	4)			
21	or th	Completed by Funeral Director	10	0		Homemal				Home
pu	should be filed within and Mental Hygiene. a marked other than "aumatic evant, Ille Men	Be (17. Father's Name (First, Middle,					me (First, Middle, I n Connell		
/la	Ment Ment arked	2	George Rhin	enart						
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene if Health and Mental Hygiene item 27 Ia marked other than "natural", or itams 23a or 28a-1 show then traumatic evant, Ita Medical Examinating routined at		19a. Informant's Name/Relations. Mary K. Johnso			ng Address <i>(Street a</i> Norman <i>A</i>			r, City or Town, State, 2 MD 21060	
	Health tem 27 other tr		Mary N. Comisc				avenue,			
ore	of He		20a. Method of Disposition 1 ☐ Burial ②☐Cremation		Place of Dispo cemetery, crer	sition (Name of natory or other plac			20c. Location - City or	Town, State
Ĕ	Pages nent of l ant: If its ary or o		'4 □Donation 5 □ Other (S		View	Crematory	y 10/27,	/2004	Baltimor	e, MD
Baltimore,	permit. Pages 1 and Department of Healt Important: If item 2 any injury or other ODCE.		21. Signature of Euneral Service	Licensee Victor P. Doda	, Jr. 2	Name and Address	ss of Facility	eral Home.	Inc.	
m	8 9 E 8 8		Vicu		71	501 E. Fort	Avenue, I	altimore M	aryland 212	30
Н	3		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused the death	h. Do not ent	er the mode of dyin	ng, such as cardia	c or respiratory arr	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Ac	270	MYDGA	RDIA	INFR	ARC FRON	Onset and Death
	/Medical		resulting in death)	Due to (or as a conseq	uence of):	1000				ZIJI CZ CON WC
н	Examiner		On the Parameter	h						
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):					
	cuted	Examiner	that initiated events	С						
o,	an ar rial-t	EX	resulting in death) Last	Due to (or as a conseq	uence of):					
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the buriat-transit	Ical		d						
9	tifica ig ph as th									
Вох	n cer andir use	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnancy	,		23d. Date of del	
	deat e atte	Icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of d		Other (specify)			Month	Day Year
Ö.	t the by th tache	Physician/Med	9 Unknown	9LI OTIKITOWI						
Э,	res that the death certifics igned by the attending ph be detached for use as t		Part II. Other significant condition	ons contributing to death but not res	ulting in the u	nderlying cause giv-	en in Part I.	23e. Did to	bacco use contribute to	3-1
ğ	w require been sig should b	ba	DEMENTIL	A MUZHEI	MZ			1 🗆 Y	es 2□No 3□Pr	obably 4 Unknown
Records,	s bee	Completed by	TARDINE	DYSKINES	SIA			24a. Was a	n 24b. Were au	topsy findings available completion of cause of
Re	9 4	E C						autops perfor	med? death? 2. Tro 1 ☐ Yes	1
a	ician: Th certificate rector, pag	a)	25. Was case referred to medica				26. Place of De	ath (Check only or	-	
Vital	yaician: is certific director,	To B	examiner? 1 ☐ Yes 2 No		ER/Outpatier	nt 3 DOA Oth	oc		ence 6 ☐Other (Spe	cify)
of	Phys rrthis aral di	-	27. Manner of Death	28a. Date of Injury	28b. Time o				ow injury occurred	
on	nding Ph th. : After th s funeral	to	1- Natural 5 ☐ Pendir 2 ☐ Accident investi		Injury		Yes 2 □No			
Division	Attanding Phyaician: r death. actor: After this certifica	fice	3 ☐ Suicide 6 ☐ Could	ained 288. Place of Illigary - At his		eet, factory, office			treet and Number or Ru	ıral Route Number,
Di	after after Direct	Certification:	4 Homicide	building, etc. (Specif	y)			City or Town	n, State)	
	Hospital	alc		ng Physician: To the best of my kno						
	Ho Ho Ho Hotel	edical	(Check only 2 Medical one)	Examiner: On the basis of examina and manner stated.	ition and/or in	vestigation, in my o	pinion, death occ	urred at the time, d	late and place, and due	to the cause(s)
_	To the Hospital or Attand within 24 hours after death To the Funaral Diractor; completely filled in by the	Me	29b. Signature and title of certifie	" Into		29c. Licens	e number	2	9d. Date signed (Monti	h, Day, Year)
			1/en/cz	dZA	MI	DO	02519	7 (01+25	2004
,			30. Name and address of person	who completed cause of death (Item	n 23a) (Type,	Print)	/	7	7	11
	7		RICHARD	F1561812	LRAC	Special Control of the Control of th	ERS 6	>LEW 1	SURW(E	MB
	Sta	ite .	31. Date filed (Month, Day, Year)	32. Registrar's Signa		no Kal	,		,	
)	Regist	ar	OCT 2 9 200	4 Branch	- Pay	we care at the life				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier 10 34452 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** *i0:38a* m 21, 2004 October 0 Alice Marie Riddle /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Arbutus Baltimore 5423 Dolores Avenue If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Yrs June 12, 1922 Maryland Director 82 216-14-8486 Usual Residence of Decedent the Maryland 10d, Inside City Limits 10b. County 10c. City, Town or Location 10a, State 28a-f show treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 27 ☐ No Director Arbutus MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 0 21227 United States Items 23a 5423 Dolores Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🕅 No Specify: Baltimore, Maryland 21215-0036 ö þ 3 XWidowed 4 ☐ Divorced "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "ne any injury or other treumatic event, the Machan once. College (1-4or 5+) Flementary/Secondary (0-12) 10 Baltimore County Bus Driver 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be Virginia Saunders William Stone Hanson 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 5423 Dolores Ave., Arbutus, MD 21227 Earl J. Riddle, Jr. 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a Method of Disposition N Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial Donation 5 Other (Specify) 10-25-2004 Elkridge MD 22. Name and Address of Facilitymbrose Funeral Home, Inc. e of Funeral Service Lice 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Quean /Medical Due to (or as e consequence of): **Examiner** Sequentially list conditions, Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the burial-transit Due to (or as a consequence of): The law requires that the death certificate be exec Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records. 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 1 ☐ Yes 2 No 1 ☐ Yes certificate Division of Vital Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only ofe Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 esidence 6 Other (Specify) 2 1 Tyes / No 28a. Date of Injury (Month, Day Year) 27. Mann ol Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 28l. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined after 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical To the within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D26307 Kanpinen

Registrar

State

LINTHICUM.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date liled (Month, Day, Year)

2 9 2004

202 W 32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** EVELYM 2000 22 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** 1204 Latrobe Drive Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year)
Aug. 15,1926 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 K F Yrs. West Virginia 236-38-6845 78 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. In side City Limits 10a. State 10b. Count show r than "natural", or items 23a or 28a-f show the Madical Exertirer roust be notified at 1 ☐ Yes 2X No Anne Arundel Arno1d 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 흅 21012 492 Colonial Ridge Lane USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes ZXNo Specify: White Specify φ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Administrative Assistant Flora1 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 2008. Charles S. Trimble Grace Griffie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Bajus (Daughter) 1204 Latrobe Drive, Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory 10/26/2004 Baltimore, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Hardesty Funeral Home, P.A 21. Signature of Funeral Service License 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed use as the burial-transit attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Live birth 2 ☐ Fetal death Year Month Dav 4□Pregnant at time of death 5 Other (specify) signed by the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Yes 2 No 3 Probably 4 Unknown been si should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 2) No 1 Yes Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 1 ☐ Yes 27 No Certification: To 2 ER/Outpatient 3□ DOA Other (Specify After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Yeer) 28d. Describe how injury occurred 27. Manger of Death Natural 2 Accident 5 Pending 2 □No death. investigation after death the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide ŏ within 24 hours a To the Funeral L Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my onicion, death accurred at the time.] 29a, Certifier Medical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier-Dr of person who completed cause/o leath (Item 23a) (Type, 104 31. Date filed (Month, Day, Year) OCT 2 9 32. Registrar's Signature State Registrar

		1	State of Maryland / [State of Maryland / [Department of He Certificate of D		ntal Hygier Reg.	2 U U 4	34454
	Dhysisis		1. Decedent's Name (First, Middle, Last)		2.		Day Year	3. Time of Death
	Physicia /Medic	al	Joseph John Ragno 4a. Facility Name (If not institution, give street and number)	4b. City. Town, or			27, 2004 4c. County of Death	
	Examin	er	Saint Joseph Medical Center		Towson			imore
	Funeral Director		213-14-9007 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	thday) If Under 1 Year Months Days	Hours Min.	Date of Birth (Month, Day, Yea IULY 15,	9. Birth Con 1922 Mart	nplace (State or Foreign untry) YLand
	and w	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow	n or Location				10d. Inside City Limits
	Maryl Ind a	tor	Maryland Baltimore	Kings	ville			1 □ Yes 2 No
	ith tha	Director	10e. Street and Number	10f. Zip Code	01067	10g. (Citizen of What Co	•
	sath w	erai	7006 Heathcoate Drive 11 Marital Status 12. Was Decedent Ever in U.S.	13 Was Decedent of His	21087	v Yas or No-	U.S.A	
20	ba filed within 72 hours efter death with the Maryland at Hygiene. A contract of the than "natural; or items 23a or 28a-f show event, it e Madical Examiner wast by notified all event.	by Funeral	11. Marital Status 1 □ Never Married 2 M Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No lit Yes, Give Year or Dates: WW 17	13. Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ※ No	Specify:	an, etc.)	Black, White	
200-0	r2 hou			Decedent's Usual Occupa (Give kind of work done di	ition uring most of working	16b.	Kind of Business/	ndustry
ž	ithin 7	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)			Construct	ian
N	filed within Hygiene. Ithar than "	e Co	12th Grade 17. Father's Name (First, Middle, Last)	Brick Mason	18. Mother's Name (F			λ0π
land	ihould ba id Mental markad o matic eva	To Be	Joseph Ragno		Josephin	ie Sc	orrentino	
ary	ges 1 and 2 should I of Health and Men If Itam 27 is marka or other traumatic		1.1.1	. Mailing Address (Street a				
o, o	s 1 and if Health Itam 27 other tr		20b. Place of	7006 Heathcoo of Disposition (Name of	Date		Location - City or	21087 Town, State
5	Pages nent of thint: If its int: If its iry or of		1 XBurial 2 □ Cremation 3 □ Removal from State cemete	ry, crematory or other place 10Ly Redeemen				Maryland
aitimore,	permit. Page Department Important: If any injury or once.	1	21. Signature of Funeral Service Licensee	22. Name and Addres	s of Facility Schu	imunek Fi	ineral Ho	mes
ñ	Der any		Dtefance Kinsker	9705 Belai	ir Rd., Bal	timore,	MD 21236	
			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final	not enter the mode of dying	g, such as cardiac or re	espiratory arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death) Due to (or as a consequence		CTIVITY			-
	Examiner	iner	SEVERE COROL	·	/ DISEASE			
	sit .		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	of):				
	and and al-tran	Examiner	that initiated events resulting in death) Last C	of):				
8760	cate be executed oblysician and the burial-transit	dical E	d					
9	ntificat ng phy s as th	Medi	IF FEMALE:					
Вох	eath certific attending p	Physician/Me	23b. Was decedent pregnant 1 Live birth 2 Fetal deat				23d. Date of deli Month	very Day Year
0	at the de by the a tached f	iysic	1 Yes 2 No 9 Unknown 4 Pregnant at time of death	5 Other (specify)				
т, Г	res that ligned by	by Ph	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause give	en in Part I.	23e. Did tobaco	o use contribute to	the cause of death?
rds	w require been sig should b	ed b	SEVERE AORTIC STENOSIS			1 XYes	2 No 3 Pr	obably 4 Unknown
Vital Records,	a a c	Completed	RENAL FAILURE			24a. Was an autopsy performed	prior to death?	topsy findings available completion of cause of
ta	sician: The ław s certificate has t lirector, page 2 s	e e	25. Was case referred to medical		26. Place of Death (0	1 ☐ Yes 2 Z	No 1	2 No
<u></u>	nysicia nis cer direct	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/O		4 Nursing nome	5 🗌 Residence	6 □Other (Spe	cify)
Division of	ing Pt After th		1 X Natural 5 ☐ Pending (Month, Day Year)	Time of 28c. Injury		d. Describe how in	njury occurred	
80	ktendi death. ctor: A y the fu	icati	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, 1		Yes 2 □ No 28i	. Location (Street	and Number or Ru	ıral Route Number,
<u>></u>	al or A after i Dirac d in by	Certification;	4 Homicide determined building, etc. (Specify)	,		City or Town, St	ate)	
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Diractor: After this certificate his completely filled in by the funeral diractor, page	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge and manner stated.	ge, death occurred at the tim nd/or investigation, in my op	ne, date and place, and pinion, death occurred	d due to the cause at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the Ho within 24 To the Fu completel	Me	29b. Signature and title of certifier	29c. License	number	29d.	Date signed (Month	h, Day, Year)
)	-		> Madal	D 5	9297		128/04	
	1241		30. Name and address of person who completed cause of death (Item 23a	(Type, Print)				
	1 7	ate	31. Date filed (Worth, Day, Year) 32. Registrar's Signature	R DRIVE TO	WSON MARY	ALAND 2	1204	
	Regist		OCT 2 9 2004 Deneura	& Spa	h			

			1- State of Maryland / De Registrar	partment of Health and Me e <i>rtificate of Death</i>	ental Hygien 1 Reg. N													
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month OCT . 25	3. Time of Death												
	/Medic	al	Edward Ramsey	th City Town and anation of Court		2004 1320 PM												
	Examir	er	4a. Facility Name (If not institution, give street and number) 3615 EDNOR ROAD	4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death												
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthda 79 Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 1ay 8, 192	9. Birthplace (State or Foreign Country) Florida												
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits												
	a-f sh	ctor	MD	Baltimore		1X Yes 2 No												
	ith the	Director	10e. Street and Number 3615 Ednor Road	10f. Zip Code	10g. C	Citizen of What Country?												
	eath w			21218 3. Was December of Hispanic Origin? (Spec	rify Vac or No-	USA 14. Race - American Indian,												
Maryland 21215-0036	172 hours after death with the Maryland "neturel", or Iteme 23a or 28a-f show dical Examinat must be notified at	by Funeral	1 Never Married 2 Married 3 Midowed 4 Divorced Amied Forces? 1 Married Forces? 1 Married Forces? 1 Married Forces?	 Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto R Yes 2 No Specify: 	ican, etc.)	Black, White, etc. Specify: black												
5-0	72 ho 'netur	eted	15. Decedent's Education 16a. De (Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of workin . DO NOT use retired)	unk 16b.	Kind of Business/Industry unk												
121	within ane. than	Completed	Elementary/Secondary (0-12) College (1-4or 5+) unk	. DO NOT use retired)														
1d 2	il Hygin other ent, I	Be Co	17. Father's Name (First, Middle, Last)	unk 18. Mother's Name	(First, Middle, Maide	en Sumame)												
/lar		To B		Rebeco	ca Ramsey													
Jan				iling Address (Street and Number or Rural														
e,	1 an Heall em 2 ther		20a Method of Disposition 20b. Place of Dis	5 Ednor Road 2nd fla		re, MD 21218 Location - City or Town, State												
Baltimore,	Page nent o ent: ff ury or		1 □ Bunai 2 □ Cramation 3 □ Heimoval from State 14 □ Donation 5 □ Other (Specify) in state	ematory or other place) 22. Name and Address of Facility														
Ba	permit. Departr Importe eny inje		Ronald S. Wave, Director	State Anatomy Board		altimore Street												
100	Pnysician /Medical Examiner		23a Part1. Enter the disease, or complications that caused the death. Do not enter the disease, or complications that caused the death. Do not enter the disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions.	inter the mode of dying, such as cardiac or	3 6	Approximate Interval Between Onset and Death												
68760,	icate be executed physician and the burial-transit	ed by Physician/Medical Examiner	by Physician/Medical	by Physician/Medical	by Physician/Medical	by Physician/Medical	by Physician/Medical	by Physician/Medical	by Physician/Medical	lical Examine	lical Examine	lical Examine	lical Examine	dical Examine	Sequentially list conditions, if any, I saury to Entherolate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):			
.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit										B □Ectopic pregnancy G □ Other (specify)		23d. Date of delivery Month Day Year					
rds, P.	n requires that been signed b should be deta									by	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death? 2 No 3 Probably 4 Unknown			
Vital Records,		Completed			24a. Was an autopsy performed?													
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)													
o	Phys rthis ral dir	Ilon: To	XX Yes 2 No Hospital: 1 □ Inpatient 2 □ ER/Outpat 27. Manner of Death 1 □ FNatural 5 □ Pending (Month, Day Year) 2 □ Accident investigation 1 □ Accident Investigation	of 28c. Injury at 28	e 5 Residence 3d. Describe how inju	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,												
Division	To the Hospital or Attending within 24 hours after death. To the Funerel Director: Afte completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		Bf. Location (Street a City or Town, Stat	and Number or Rural Route Number, ite)												
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, de to the basis of examination and/or and manner stated.	ath occurred at the time, date and place, ar investigation, in my opinion, death occurred	id due to the cause(s I at the time, date ar	(s) and manner as stated. nd place, and due to the cause(s)												
	To the with the To the comp	Ň	29b. Signature and title of certifier Leodor U Line / 1940	29c. License number O • C • M • E		Date signed (Month, Day, Year) OCT • 25 , 2004												
			30. Name and address of person who completed cause of dath (Item 23a) (Typ	e, Print) n Street, Baltimore,	Maryland	21201												
	Sta Regista		31. Date filed (Month, Day, Year) OCT 2 9 2004 32. Registrar's Signature	Sour	-													

04-06928 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie**2e()** () Last tem 1 per me G837 11-23-04 Las Registrar Certificate of Death Reg. No. Dwight Maurice Sellmon 34456 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death October 26, 2004 **Physician** an 0054A. Mauric /Medical 4a. Facility Name of not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrş. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign **Funeral** Days 10 M 2□F Months Hours Min 314-96-970 Usual Residence of Decedent Director 10a State 10h Counts 10c. City. Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Madical Examiner rust be notified at 1 Yes 2 □ No Maryland Director more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Items 23a d 21 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT, use retired) 16b. Kind of Business/Industry 12 should be filed within 7/ h and Mental Hygiene."n 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) aborei 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wigh Maurice sellman Print) (Sister) Informan ' ame/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traun 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State emetery, crematory or other place) 1 ⊠Burial 2 □ Cremation 3 □ Removal from State 2004 * 4 ☐Donation 5 ☐ Other (Specify) Or re of Funeral Service License 22. Name and Address of 21. Signatu once Funeral Horve. Balto. Home Joseph L. Kus 2222 W. North AVR. 21216 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Multiple Gunshof /Medical Due to (or as a consequence of) **Examiner** Sequentially list concilions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit certificate be executed Due to (or as a consequence of): Box 68760 physician Physician/Medical the as IF FEMALE use a If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No jo Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. the detached 9☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð pe 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1 X Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 1 Yes 2 □ No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 XYes 2 🗌 No this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation Injury death. 1 🗌 Yes subject was shot 2 Accident 10126104 12:03 after death Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide Butto, MD street bik. of W. 24 hours a 2800 waterette st. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) To the I within 2. To the I and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E. October 26, 2004 outhail. Ms 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			AL AL	partment of Health and I ertificate of Death		ene 004	34457	
	Physici /Medi		1. Decedent's Name (First, Middle, Last) Walter J. Strug/	inski	2. Date of Death Month	21 04	3. Time of Death C 8: 55 M	
1	Examir	ier	4a. Făcility Name (If not institution, give street and number) St. Catherines Nursing Home	4b. City, Town, or Location of Death Emmitsburg	1	4c. County of Death	riche	
	Funeral Director		5. Social Security Number 295—18—0695 6. Sex 1 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Months Days Hours Min	8. Date of Birth (Month, Day, April 10	9. Birthpi Coun 0,1923 Akro	lace (State or Foreign try) n, OH.	
	ith the Maryland or 28a-f show	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or OHIO Stark Nort	Location Ch Canton		10	0d. Inside City Limits 1 Yes 2 No	
	th with the 23a or 28s	al Director	10e. Street and Number 1149 Linwood Avenue	10f. Zip Code 44720	100	g. Citizen of What Coun	try?	
5-0036	hours after death with the Maryland lural', or items 23a or 28a-f show al Evantrar must be rodified at	by Funeral	1 Never Married 2 0 Married 1 Serves 2 No If Yes, Give 1 Yes, Give 1 Year or Dates:	3. Was Decedent of Hispanic Origin? (Sr If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	pecify Yes or No- Rican, etc.)	14. Race - America Black, White, 6 Specify: W		
21215-0	within 72 ane. than "nat	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12	cedent's Usual Occupation we kind of work done during most of work . DO NOT use retired) Shift forma	king	Sb. Kind of Business/Ind	ustry u Facturily	
Maryland 2	Q ta 20 9	To Be C	17. Father's Name (First, Middle, Last) Stanley Struglinski	18. Mother's Nam	ne (First, Middle, Ma	siden Sumame)	0	
	rt 2 mg			iling Address (Street and Number or Run 9 Linwood Avenue N				
Baltimore,	m O h.		1 Rurial 2 Comption 2 Removal from State Cemetery, Ci	rematory or other place)		c. Location - City or Too adsworth, Oh		
Balt	permit. Page Department of Important: if any injury or		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Charles L. Steve 1501 East Fort A	ns Funera	al Home Inc	1230	
8760,	Physician /Medical Examiner building physician and physician and sthe pnial-transit	ompleted by Physician/Medical Examiner	23a. Part1. Enter the disease, or complications than caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	ed Demen atu Cardio	tis		Approximate Interval Between Onset and Death	
.O. Box 6	death certif e attending d for use as			□Ectopic pregnancy □ Other (specify)		23d. Date of deliver Month	y Day Year	
Records, P.(The law requires that the diate has been signed by the page 2 should be detached			Completed by Ph	Part J. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part !. Lift Froh	1 X Yes 24a. Was an autopsy performer	prior to com death?
of Vital	ysician: Th is certificate director, pag	To Be C	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	Othorn	1 Yes 2	No 1 ☐ Yes 2 e 6 ☐ Other (Specify)		
Division of	or Attending Ph ufter death. Director: After th in by the funeral	Certification; T	27. Manner of Death 1 \$\frac{1}{N}\$ Natural	of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how	injury occurred et and Number or Rural		
_	To the Hospital within 24 hours a To the Funeral I completely filled	Medical Co	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deal control on the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the caus ed at the time, date	e(s) and manner as state and place, and due to t	ted. he cause(s)	
	To th within To th compl	Me	29b. Signature and title of certifier	29c. License number 05 05	-	Date signed (Month, Date i 0 2 2 1 0	ay, Year)	
	0		30. Name and address of person who completed cause of death (Item 23a) (Type Alan Carroll MI) 310 S. Set	, Print)		Md 217	27	
	Sta Registr		31. Date filed (Month, Day, Year) OCT 2 9 2004 32. Registrar's Signature	Sparks	1			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year october 27 2004 /Medical Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BAL KINS JOHNS HOP N/A 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year Under 24 Hrs. 9. Birthplace (State or Foreign Country) West Virginia 8. Date of Birth (Month, Day, **Funeral** Months Days Hours 123M 2□ F 56 Yrs. 219-50-3549 Director 29, Jun 1948 Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Mudical Examiner must be notified at Director 1 Yes 2 No MD Baltimore Dundalk 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 101 Center Place, Apt. 301 21222 or itams 23a United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. withIn 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 Specify: White ð 1 Yes 2 No Specify: 3 ☐ Widowed 4 St Divorced Year or Dates: natural Completed 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Construction than Elementary/Secondary (0-12) Hygiene. College (1-4or 5+) Painter 12 marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) es 1 and 2 should be fill of Health and Mental Hill flem 27 is marked oth Be Earl Eugene Spencer Betty Pelphrey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Angela Spencer/Daughter 2413 Chetwood Circle, Lutherville, MD 21093 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of h Oct 30 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Important: If any injury o Chesapeake Crematory * 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD 2004 21. Signature of Funeral Service Licenses once ²². Name and Address of Facility Cremation and Funeral Alternatives MO0984 8717 Green Pastures Drive MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner TVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events to (or 15 a consequence of) Examiner certificate be executed burial-transit and resulting in death) Last as a consequence of) Box 68760 ed by the attending physicien detached for use as the buris Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown signed by it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ **Z**Únknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has 1 Yes Division of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ě 2 2 ER/Outpatient 3 DOA inis 28a. Cate of Injury (Month, Day Year) 28b. Time of Injury completely filled in by the funeral 27. Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 5 Pending death. investigation 1 □ Yes 2 No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide within 24 hours a To the Funerel L To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 who completed cause of death (Item 23a) (Type, Print) OCT 2 9 2004 31. Date fit 32. Registrar's Signatu State Registrar

DHMH 17 Rev 1/2001

			For State	State of	Maryland		artment of H			21111	34459	
			1. Decedent's Name (First, Middle	le. Last)			lilicate of L	Jeani	2. Date of Deat	y. 140.	3. Time of Death	
	Physici			. Stansbu	0				Month	Day Y	ear	
	/Medio Examir		4a. Facility Name (If not institution				4b. City, Town, or		October	24 200 4c. County of		
1	LXamii	161	Anne Arundel		Center			_				
	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. la		Annapol If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Anne A	. Birthplace (State or Foreign	
	Director		214-56-0308	M 2□F	51	Yrs.	Months Days	Hours Min.	Month, Day,		Country)	
	pu ≱		Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Lo	aation				-	
	Aaryk sho	ō									10d. Inside City Limits PDYes 2 □ No	
	28e-1	Director	Maryland Anne	e Arundel	Gle	n Bu	rnie 10f. Zip Code		4/	No. Ohio		
	with the or						Tot. Zip Code			g. Citizen of Wha		
	ns 23	era	1413 Oakdale	Road 12. Was Decede	ent Ever in U.S.	. 13. \	2106 Was Decedent of His		necify Yes or No-	US 14 Bace -	A American Indian,	
36	d within 72 hours after death with the Maryland Jiene. I then "netural", or Items 23a or 28e-1 show The Medical Examera must be rediffed at	by Funeral	1 ☐ Never Married 25 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forc	턴 No es?		fYes, specify Cubar □ Yes ≱∰tNo	Specify:	o Rican, etc.)		White, etc.	
21215-0036	2 hou	edi	15. Deceden	it's Education		16a. Deced	lent's Usual Occupa	tion		6b, Kind of Busin	ness/Industry	
215	C 2 6	Completed	(Specify only highe Elementary/Secondary (0-12)	st grade completed) College (1-4		(Give	kind of work done d OO NOT use retired)	uring most of wor	king	ob. Italia of Basil	io da industry	
21	filed withi Hygiene. other then	mo;	12th	O College (1-4	0(34)	Ca	rpenter		\$6	elf Emp	loved	
b	be filed tal Hygie d other event,	Be	17. Father's Name (First, Middle,	Last)				18. Mother's Nan	ne (First, Middle, M		10 y.Cu	
yla	should be nd Mental marked o	2	Robert V. S	Stansbury					e Smith			
Maryland	and s m		19a. Informant's Name/Relations				g Address (Street a.					
	1 and 2 Health em 27 I		Talayaha Star 20a. Method of Disposition	sbury (D	aughte	r) 52	2 Driftw	ood Cor			yland 21221	
٥	Pages 1 ar		1-1 Burial 2 ☐ Cremation	3 □Removal from St	Mt.		natory or other place 1 UM Chu	rch	Date	Oc. Location - Cit	y or Town, State	
Baltimore,			4 □ Donation 5 □ Other (S21. Signature of Funeral Service			eter		10.	/29/04 I	asaden	a, Maryland	
Ba	permit. Departr Importa any inju				UOA	Wm	. Reese	& Sons	Mortuar	v, P.A	-	
			Jarry 3.	complications that cau	sed the death.	Do not ent	21 West or the mode of dying	St. Ana	napolis,	Md. 2	1401 proximate	
1	Pnysician		Immediate Cause (Final	only one cause on each	n line.						Interval Between Onset and Death	
1	/Medical		disease or condition resulting in death)	a. Due to (or	as a conseque	nce of):						
п	Examiner		Sequentially list conditions	b. #1	V·							
	de is	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a conseque	nce of):						
V	and and il-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or	as a conseque	nce of):						
68760,	icate be executed physician and s the burial-transit				,							
687	* 7	edical		d.						W		
Вох	law requires that the death certifi as been signed by the attending 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregnand		Ectopic pregnancy			23d. Date of	f delivery	
	ne deat the att	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No		t at time of dear		Other (specify)			Month	Day Year	
P.0.	that the di ed by the detached	Phy	9 Unknown									
	signed t	by	Part II. Other significant condition	ely over				n in Part I.			te to the cause of death?	
0.00	w requir been si should	etec									Probably 4 Unknown	
of Vital Records,	0 - 0	Completed	General	Pelly					24a. Was an autopsy performe	prior	e autopsy findings available to completion of cause of	
	icien: The certificate harefor, page		OF Man ages referred to madical						1 Yes 21	No 10	Yes 2□ No	
<u> </u>	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2/☑/No	Hospital: .	ationt OFF	2/0-4	0.0		th (Check only one)			
	y Phys er this eral di	\vdash	27. Manner of Death	28a. Date of I	atient 2□EF njury 2t	8b. Time of	3 DOA 28c. Injury Work	4 Nursing H	ome 5 Residen		Specify)	
lon	Attending Fir death. ector: After by the funer.	atio	1 Natural 5 ☐ Pendin 2 ☐ Accident investig	9	Day Year)	Injury		es 2 🗆 No		od. Describe now injury occurred		
Division	ol or Attend after death Director: / d in by the f	Certification:	3 Suicide 6 Could i	ined 286. Place of	Injury - At home	e, farm, stre	et, factory, office		28f. Location (Stre City or Town,	et and Number o	r Rural Route Number,	
	itel or rs afte rel Dir	Cer		Daniel 19	oto. (opacily)				Oily or TOWIT,	State)		
	e Hospitel of 24 hours a e Funerel Dietely filled i	edical	CHIOCK ONLY IZ MINIBUICAL	g Physician: To the be Examiner: On the basis	est of my knowle s of examination	edge, death	occurred at the time	, date and place,	and due to the cau	ise(s) and manne	r as stated.	
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Med	one) 29b. Signature and title of certifier	and maniner	stated.		29c. License			d. Date signed (M		
	1 × 1 × 0											
•			30. me and address of person		WiOPN			1028			4	
			600 Ridall	· Aug	Such	-e	231	Annay	bolus M	0 214	.0,	
-	Sta Registr	te ar	31. Date filed (Month, Day, Year) OCT 2 9 2	32. Reg	istrar's Signatur	4	p	7				
				1		6/	Ann					

State of Maryland / Department of Health and Mental Hygiere Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 24 12:40P 2004 October 0 Marjorie Sylvester /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Charlestown Retirement Community Catonsville Baltimore Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/9/1913 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 ☐ M 2 🔀 F 91 058-09-2589 New York Director Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Items 23s or 28s-f show ury or other traumatic event, the Maylord Ext. illiver will be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No by Funeral Director United States MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9318 Northgate Rd 20723 United States 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White 3 ⊠ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker <u>Own home</u> 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Nicholas Deters Isabel Gogan ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 910 Stornont Circle Baltimore, Maryland 21227
ce of Disposition (Name of Date 20c. Location - City or Town, State Jim Sylvester / son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Peges 1
Department of H
Important: If ite
any injury or ott 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State 10/27/2004 Laurel, Maryland Union Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home Inc 21. Signatu 1328 Sulphur Spring Rd Baltimore, Maryland 21227 ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e. List only one cause on each line. Approximate 23a. Part1. Enter the disease shock, or heart failure. Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequent) of): **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of). Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the detached o 9 Unknown 9 Unknown signed by ئە 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Dysphagia Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed: certificate ! 2X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending 5 Pending Injury 1 M Natural after death.

Director: Aff 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours after To the Funeral Direct To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number , mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 711 Maiden Choice Lane Cotonsville, no 21228 Deneen Bowlin, min 32. Registrar's Signature 31. Date filed (Month, Day, Year) State oaks 2 9 2004 Registrar

DHMH 17 Rev 1/2001

		Plea	ase Type or Pi								
		1 - For State Registrar	State of r	Maryland / D		rtment of He tificate of E			giene Reg. No.	004	34461
Physici	an	Decedent's Name (First, Middent Mary Agnes	Sulock					2. Date of De Month	ath Day	Year	3. Time of Death
/Medic		4a. Facility Name (If not institution		or)		4h City Town or	Location of Death	October			9:30 AM ^M
Examin	er			91)		4b. City, Town, or			4C. C	ounty of Dea	tn
Funeral		Friends Retir 5. Social Security Number	6. Sex 7.	Age (In yrs. last birth	nday)	Sandy S If Under 1 Year Months Days	f Under 24 Hrs. Hours Min.	8. Date of Bir	th Vear	ontgom 9. Bir	thplace (State or Foreign
Director		165-14-9744 Usual Residence of Decedent	1□ M 2CX F	83 Y	rs.	Months Days	Hours Mill.	8. Date of Bir (Month, Da March	27, 1	921 Î	ennsylvania
land ow		10a. State 10b. County	у	10c. City, Town	or Loc	ation					10d. Inside City Limits
a-f sh	ctor	MD Mont	gomery	Sandy S	Spr	ing					1 ☐ Yes 2 ☐ No
with the a or 28	Funeral Director	10e. Street and Number 17340 Quaker	Lane			10f. Zip Code 20860				on of What Co	ountry?
s 23	ra			- S	10.11			- '7 - V N	US		7
be filed within 72 hours after death with the Maryland ital Hygiene. In the Maryland of other than "natural", or Items 23a or 28s-f show event, the Madical Examinar intestine notified at	by Fune	11. Marital Status 1 Never Married 2 Ma	. If Yes, Give 2	os? ⊋No ∆	lf	/as Decedent of His Yes, specify Cuban ☐ Yes 2 ☑ No	Specify:	Rican, etc.)		I. Race - Ame Black, Whit Specify:	
2 hours			Year or Date	s: 16a. [Deced	ent's Usual Occupa	tion			d of Business	
hin 72 in "na	ompleted	(Specify only higher Elementary/Secondary (0-12)	est grade completed) College (1-4c		Give k life. D	rind of work done du O NOT use retired)	uring most of wor	king			
d with	Com	12	00,1090 (1 40	5. 5.7)		Homemake	r		Own	Home	
ld be file ental Hy kad oth ic event	o Be (17. Father's Name (First, Middle Harold Staub	e, Last)				18. Mother's Nam Agnes	e (First, Middle, McLaugh		umame)	
nd 2 shoulth and M 27 Is mai		19a. Informant's Name/Relation Tina Lehman	nship (Type, Print) (Daughter)			Address (Street at					Zip Co de)
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 271s marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examination institutional page.		20a. Method of Disposition 1 🗓 Burial 2 □ Cremation 1 □ Donation 5 □ Other (3		10	, crem	ition (Name of atory or other place Cemetery		Date 28-04		ation - City or yn, Pe	Town, State
permit. Departr Importe any inje		21. Signature of Funeral Service	a Libensee	QQ		Name and Address Decker Fu		me minster	. PA	18974	
100	1	23a. Pirt 1 Enter the disease, o	or complications that caus	sed the death. Do no		CONTRACTOR OF THE PARTY OF THE			-	10,7	Approximate
Physician		shock, or heart failure. Lis immediate Cause (Final disease or condition	st only one cause on eacr	denoca				100			Interval Between Onset and Death
/Medical		resulting in death)		as a consequence of		(PTOTAL)	,	1.01			7 months
Examiner		Sequentially list conditions.	b								
sit ad	mlner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or a	as a consequence of):						
executed in and ial-transit	×	that initiated events resulting in death) Last	c. Due to (or	as a consequence of	7-						
be exician buria	alE				,.						
phys phys s the	dlc		d.								Jan 1991
The law requires that the death certificate be exate has been signed by the attending physician age 2 should be detached for use as the burial	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 mo ths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		2 Fetal death		Ectopic pregnancy Other (specify)			23	d. Date of del Month	ivery Day Year
res that igned by be deta	y Ph	Part II. Other significant condit.	tions contributing to death	h but not resulting in t	the un	derlying cause giver	n in Part I.	23e. Did to	bacco use	contribute to	the cause of death?
w requires been sign should be	ted by	Hyper	tension					1 🗆 Y	es 2.2	No 3□Pr	obabiy 4 Dunknown
The law rate has be page 2 sh	Completed	Hyperl	1. pidem	wlar	7	Diseas		24a. Was autop perfor		prior to death?	topsy findings available completion of cause of
	0	25. Was case referred to medica	al Viss	will	1		26. Place of Deat			1 🗆 Yes	2 2 No
Physiclen: r this certific ral director,	OB	examiner? 1 ☐ Yes 2X No	Hospitat:	atient 2 ER/Outp	atient		4 Nursing Ho			Other /Sno	cify)
g Ph	n; T	27. Manner of Death	28a. Date of Ir		ne of	28c. Injury	at	28d. Describe h			
Attending Physiclen: sr death. ector: After this certification by the funeral director.	ification;		tigation	ouy roury in	ury		es 2 No				
Att.	iffe	3 ☐ Suicide 6 ☐ Could	not be 28e. Place of	Injury - At home, farn	n, stre	et, factory, office		28f. Location (S	treet and	Vum <i>ber</i> or Ru	ral Route Number,

Division of Vital Records, P.O. Box 68760, S To the Hospitel or Attend within 24 hours after deatl To the Funerel Director: completely filled in by the

Baltimore, Maryland 21215-0036

State Registrar

Medical Certiflo

4 🗌 Homicide

29a. Certifier (Check only one)

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28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Diun Broderick M.D 18109 Prince Philip # 275 Olney, MD 20832

31. Date filed (Month, Day, Year)

OCT 2 9 2004

29c. License number

29d. Date signed (Month, Day, Year)

October 22, 2004

October 22, 2004

Aparls

Aparls

28f. Location (Street and Number or Rural Route Number, City or Town, State)

			1 - For State Registrar	State of Maryland		artment of H tificate of I		Mental Hyg	giene Reg. 200	4 34462
	Dhariai		1. Decedent's Name (First, Middle, Las					2. Date of Dea Month	ath Day	3. Time of Death
	Physici /Medic		John H.	Schmidt				0ctober	24 2	2004 11:10 PM
	Examin	er	4a. Facility Name (If not institution, give Chester River Man			4b. City, Town, or Cheste	Location of Deat	1	4c. County o	
			5. Social Security Number 6. S		st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt		ent 9. Birthplace (State or Foreign
	Funeral Director				2 Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Day March 2	28 1912	Country) MD
	PL .		Usual Residence of Decedent 10a. State 10b. County	10c City	Town or Lo	cation				10d. Inside City Limits
	shoy shoy	'n			TOWITOT ED		locido			1 ☐ Yes 2 ☑ No
	the N	rect	Maryland Queen /	Anne		10f. Zip Code	leside		10g. Citizen of W	/hat Country?
	3a or	Funeral Directo	2260 Goldsboro Ro	oad		2	1644		US	SA
	death	ner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No- o Rican, etc.)	14. Race Black	e - American Indian, k, White, etc.
9	or ite	y Fu	1 Never Married 2 X Married	1 XYes 2 No If Yes, Give		1 ☐ Yes 2 ☒ No	Specify:		Specify:	White
D-00-c	hours tural',	ed by	3 Widowed 4 Divorced	Year or Dates:	16a Dece	ient's Usual Occup	ation		16b. Kind of Bus	siness/Industry
<u>.</u>	in 72 n "ne	piet	(Specify only highest gra		(Give life.	kind of work done of DO NOT use retired	during most of world)	rking		,
7	d with giene	Completed	10	College (1-401 5+)	[Brakeman			B&O Rai	lroad
yland	be file tal Hy d oth	Be (17. Father's Name (First, Middle, Last)				18. Mother's Nar Unknow		<i>Maiden Sumame</i> einzman	9)
<u> </u>	Men Marke Marke	2	John Schmid		10b Mailir	ng Address (Street				State Zin Code)
2	d 2 st th and 7 is n treun		19a. Informant's Name/Relationship (Dora Schmidt	(spouse)) Goldsbo				
ย์	Heal Heal tem 2		20a. Method of Disposition	20b. Pla	ce of Dispo	sition (Name of natory or other place	0 - 1	Date 28		City or Town, State
Ē	Pages ent of nt: If I		1 ☐ Burial 2 【XCremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specif	Removal from State		ematory I		2004	Baltimo	ore, Maryland
Baltimor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "netural", or Items 23a or 28e-f show amy injury or other treumatic event, the Marked Examiner is until be mufflind at ODGE.	ĺ	21. Signature of Funeral Service Live	see	22	. Name and Addres	•	Sta ad, Pasa	llings F dena, MD	uneral Home,P., 21122
	3.1	Г	23a. Part1. Enter the hease, or com shock, or heart fail re. List only	plic tio s hat caused the death.	Do not ent					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	VAlzhein			ement			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):					
	Examine.	70	Sequentially list conditions,	bbue to (or as a conseque	mes of,					
П	uted I	Examiner	n any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
Ď	an and		resulting in death) Last	C. Due to (or as a conseque	ence of):					
9/p	aath certificate be executed attending physician and for use as the burial-transit	lical		d						5-60
Õ	ertifica ding pl	Med	IF FEMALE:	23c. If yes, outcome of pregnance	CV				204 Date	a of delivery
X Q Q	death c	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal of	leath 3	Ectopic pregnancy Other (specify)	,		Mon	e of delivery hth Day Year
j.	the de y the tched	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						
	w requires that the de been signed by the should be detached	by Pł	Part II. Other significant conditions of	contributing to death but not result	ting in the u	nderlying cause giv	en in Part I.			ibute to the cause of death?
g	requires een sign hould be					······		1 🗆 Y	′es 2. 🗹 No :	3 Probably 4 Unknown
ecords	law re as be	ompieted						24a. Was autop	sv pr	Vere autopsy findings available rior to completion of cause of
<u> </u>	The taw cate has	Con						1 Yes	rmed? de 2 No 1	eath? □ Yes 2 □ No
VITal	Physicien: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth		ath (Check only o		
ō	Phys r this ral di	: To	1 Yes 2 No 27. Manner of Death	1 Inpatient 2 E	28b. Time o	it 3 DOA	4 - Nursing r		dence 6 Other	
0	Attending Indeath. ector: After by the funer	atior	1 Natural 5 Pending 2 Accident investigation		Injury		K? Yes 2 □ No			
DIVISION	or Attendii after death. Director: A in by the fu	Certification:	3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location (S City or Tow	Street and Numbe vn, State)	er or Rural Route Number,
2	pitel ours af arel D		SOO Continue of Continues Of	version. To the heat of my know	lodge deet	a accurred at the tim	no data and place	and due to the	cause/s) and man	anar as stated
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fo	edical		nysician: To the best of my know miner: On the basis of examination and manner stated.						
	To th withir To th comp	Me	29b. Signature and title 13 strifler			29c. Licens			1	(Month, Day, Year)
)	\						00588	24	10/3	25/04
	V		30. Name and address of person who Paul Donaher, M.	completed cause of death (Item 2 D., 119 C N. Ma			, MD 216	35		
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) OCT 2 9 2	32. Registrar's Signatu		1				
			001702	UUT AAAA		400	-			

DHMH 17 Rev 1/2001

ORIGINAL

Thomas G. Sisler, Jr. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-06897 State of Maryland / Department of Health and Mental Hygiene 0 14 Tas Certificate of Death RJDecedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Thomas Barry Sisler, Jr. 24, 07:02 P.M October 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carroll County If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F Days 40 Director 184-58-5683 Nov. 1963 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28e-f show treumatic event, the Medical Examiner a ust be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Carroll Hampstead the 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 0 1806 Harrowsmith Court 21074 U.S.A. items 23e death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. ont of Health and Mental Hygiene. ont: If item 27 is marked other then "neturel", or iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Tax Manager Accounting 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Barry Thomas Sisler Sharon Sabo ဂ 19a. Informant's Name/Relationship (Type, Print) (wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Karen Powderly Sisler 1806 Harrowsmith Ct., Hampstead, MD 21074 other 20b. Place of Disposition (Name of cemetary, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State ŏ Department of Importent: If any injury or once. `4 □ Donation 5 □ Other (Specify) Waynesburg, PA Greene Co. Mem'l Park 10/30/04 22. Name and Address of Facility Schimunek Funeral Homes of Funeral Service bioensee 23a. Part. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. 9705 Belair Rd., Baltimore, MD Approximate Interval Between Onset and Death Immediate Cause (Final Hypertensive cardiovascular disease PHysician disease or condition resulting in death) /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed the burial-transi Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 DUnknown 24a. Was an autopsy performed?

after death Director:

Be Completed 은 Certification:

24b. Were autopsy findings available prior to completion of cause of death?

120 es 2□ No 1 X Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 No 2 X ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number OCME October 25, 2004

State Registrar

30. Name and address of person who completed gause of death (Ifem 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 THEWASSILL 31. Date filed (Month, Day, Year) OCT 2 9 2004

11

2. Registrar's Signature

To the Hospital or Attending Physicien:

124 hours at

To the

Registrar

Smith, bearge

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie 20 0 4 34465 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) October 27, 2004 0010 Robert Aiken Schultheis 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Upper Chesapeake Medical Center Bel Air Harford 8. Date of Birth (Month, Day, Ye Oct. 30, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)), 1941 Pennsylvania Months Days 1**2** M 2□F Hours Yrs. 186-32-1094 62 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 1X Yes 2 No Maryland Harford Bel Air 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21014 USA 816 Dora Place Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1X Yes 2 1 Never Married 2 Married 2 No 1 ☐ Yes 2 ☐ Wo Specify: Specify If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Proprietor Retail Sales Store 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Schultheis 5 4 1 Maginess Adam (nmn) Ruth (nmn) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8715 Littlewood Road, Baltimore, Maryland 21234 Scott R. Schultheis / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 11-29-04 Towson, Maryland 4 □ Donatign 5 □ Other (Specify) 21. Signature of Fune all Service Licenses McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications had a used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one crust on yath line. Approximate Interval Between Onset and Death Immediate Cause (Final -MONARY DAYS EDEMA disease or condition resulting in death) Due to (or as a consequence of): 6 YEARS AR DIOMYOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): DISIZASIZ DROWARY AKTIERY 1) YEARS Due to (or as a consequence of) d 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) _ 9 Unknown 23e. Did tobacco use contribute to the cause of death? ESOPHAGEAL CANCER 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 3 DOA 28a. Date of Injury 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred (Month, Day Year) Injury 1 X Natural 5 Pending investigation 1 ☐ Yes 2 👿 No М 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

27 Is marked other then "natural", or Items 23a or 28a-f show treumatic event, I've Medical Examinar must be notified at Baltimore, Maryland 21215-0036 d 2 should be filed within 72 h and Mental Hygiene. 7 Is marked other then "na permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tre **Physician** /Medical **Examiner** the attending physician and hed for use as the burial-transit certificate be executed Division of Vital Records, P.O. Box 68760 Hospital or Attending Physicien: 24 hours a Funerel [within 2 To the I

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

Funeral

Director

the Maryland

0/27/04

Examine that initiated events resulting in death) Last Physician/Medical IF FEMALE 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 25. Was case referred to medical examiner? 2 27. Manner of Death Certification: 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 31856 10/28/2004 602 S- ATWOOD RD HICK SEL AIR MD 21014 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHARMA, MO

31. Date filed (Month, Day, Year) OCT 2 9 2004

32. Registrar's Signature

Registrar

LEONID SHEVEHUK ATTENT KNOWN AS

Amend item # 18, per FH, G836, 10/29/04, TI
State of Maryland / Department of Health and Mental Hygiene 0 14 1- State AMEND ITEM #18 PER FH C837 Perificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** () CTIBER LEONID SHEVCHUK 18:55 1 26 2014 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Deaf Examiner BALTIMORE BALTIMORE PITALOF N/A 8. Date of Birth (Month, Day, Year) JUN.29,1938 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 M 2□ F Days Hours 66 Director 215-92-5586 RUSSIA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28e-f show other treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö or Items 23a 2418 HUNT DRIVE 21209 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2X Married 1 ☐ Yes 2 No Specify: WHITE Specify δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. ELECTRICAL ENGINEER ENGINEERING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Unknown Be 2 should be f and Mental h TSRAFL SHEVCHUK CHAI DEVORA DE VORA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I 2418 HUNT DRIVE - BALTIMORE, MD 21209 EMONA SHEVCHUK / WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If ite
any injury or oti 1 Burial 2 Cremation 3 Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW CEM. 10/28/2004 REISTERSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses C, Kusu Edwara 18900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOCARDIAL INFARETION **Physician** disease or condition resulting in death) /Medical Examiner OSCLETIOTIC METRI DISEASE Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine burial-transit that initiated events resulting in death) Last Due to (or as a consequence of). Box 68760. Physiclan/Medlcal the ydq gnibr IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ MYPERTENSION 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed STAGE RENAL PALLITRE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22 No 2 No 1 🗌 Yes 1 Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No npatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 5 Pending To the Hospitel or Attendii within 24 hours after death. To the Funerel Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES-000 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address SINAI HOSPITAL OF BALTIMORE FISSMA UGETA

DHMH 17 Rev 1/2001

State

Registrar

32. Registrar's Signature

OCT 2 9 2004

State of Maryland / Department of Health and Mental Hygiene

For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) **Physician** TYSON FLORINE OCTOBER 24, 2004 12:40 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** PRINCE GEORGE'S 6102 GOTHIC LANE BOWIE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🙀 F Yrs. Director WEST VIRGINIA 105-22-4820 AUG 16, 1929 75 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show in then "naturel", or Items 23e or 28e-f sho 1 No Yes 2 No Directo MARYLAND PRINCE GEORGE'S BOWIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6102 GOTHIC LANE 20720 U.S.A. filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 📆 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry ring most of working (Specify only highest grade completed) Is marked other then Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be filteent of Health and Mental H tent: If item 27 Is marked of MAUREEN RETD RUBEN BEATTY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) JAMES LEROY TYSON/HUSBAND 13310 NEW ARCADIA LANE, UPPER MARLBORO, MD 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If eny injury or once. MARYLAND VETERANS 11/01/2004 | CROWNSVILLE, MARYLAND 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ROBERT E. EVANS FUNERAL HOME, 16000 ANNAPOLIS ROAD, BOWIE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ARRHYTHMIA 6 MINUTES /Medical Due to (or as a consequence of):
CORONARY ARTERY DISEASE Examiner 5 YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, that initiated events resulting in death) Last Due to (or as a consequence of): ding physician Completed by Physician/Medical the 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 1 Yes 2 No 3 Probably 4 Nonknown peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an SEIZURE DISORDER autopsy performed? 1 Yes 2 No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To within 24 hours after death.

To the Funerel Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Xiatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

29a. Certifier

29b. Signature and title of certifier

Medical

31. Date filed (Month, Day, Year) 0CT 2 9 2004

Dwermein

DEBORAH WEINREICH, MD., 13960 BALTIMORE AVE., LAUREL, MD 32. Registrar's Signature

mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D28623

29d. Date signed (Month, Day, Year)

10/26/04

State of Maryland / Department of Health and Mental Hygier 2004 1 - For State Ragistra 34468 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October 28. 12:00 A M CHARLES THOMPSON 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9408 Dawn Drive Baltimore Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Jan. 21, 1928 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1**⋈** M 2□ F Maryland Yrs Director 217-22-7968 76 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show item 27 is marked other than "netural", or items 23a or 28e-f show other traumstic evant. Ite Mudical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Baltimore. Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9408 Dawn Drive 21236 u.s.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No δ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "r College (1-4or 5+) Elementary/Secondary (0-12) 8th Grade Longshoreman Shipping Union 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Edward Thompson Maude Jenkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is m any injury or other traum once. Mrs. Margaret Thompson (wife) 9408 Dawn Drive, Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Parkwood Cemetery ^¹ 4 □ Donation 5 □ Other (Specify) 11/01/2004 Baltimore, Maryland 21. Signature of Euneral Service License 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final _gPnysician disease or condition resulting in death) METASTATIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit Due to (or as a consequence of): 68760 Physician/Medical use as the Box (IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) the o. 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ØYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 No of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ۵ 1 🗌 Yes 1 Inpatient 2 EN/Outpatient 3 DOA (his 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Division the Hospitel or Attending Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a e Funeral L Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and 29d. Date signed (Month. Dav. Year) person who completed cause of death (Item 23a) (Type, Print) 30. Name and addr ERREDR STE 101 ALEXANDER 120 SISTER 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001

62-01 COQ

700

Thompson

State of Maryland / Department of Health and Mental Hygiene For State Registra 34469 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day inorson Marit 6:00PM 10 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Home Monta Rockville Nursing omes If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Feb 25, Birthplace (State or Foreign Country) **Funeral** Days Director 092-01-7900 90 Sweden Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b County 10c. City, Town or Location 28a-f ahow 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or itema 23a or 28a-f ahov ury or other traumatic event. The Mcdical Examinar is ust be notified at MD Completed by Funeral Director Montgomery Rockville 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 303 Adcare Road 20850 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 💢 No white Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fredrik Ferdinand Woods-Beckman 2 Frieda Dilthey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ingrid Mongini/daughter 5541 Mohican Road Bethesda, MD 20816 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ፟ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or 21. Signature of Funeral Service Licensee State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 once. Director neur 23a. Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DIYTINSIUL /Medical Due to (of as a consequence of) Examiner Cong Bhi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physiclan/Medical Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed rial burial-tran Due to (or as a consequence of): P.O. Box 68760, the attending physician the IF FEMALE for use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ page 2 should be 1 Yes 2 No 3 Probably 4 Minknown Completed Deen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No this certificate has autopsy performed 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 Inpatient 2 ER/Outpatrent 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Natural s after dec. 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examitrier: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) wown - TUSEN L 330 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OCKVIII. LUCKETTIN 8 82. Registrar's Signature State Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiepe 1- State Registrar AMEND TIEM #1 PER PHY G836 16956 16956 Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** THOMAS TYRONE THOMAS notober 2004 /Medical 23. 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Hospital Hopkins 6. Sex Itimore Ba NZA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours 1□ M 2□ F Days 220 64 0088 Yrs Director 46 Oct 06,1958 MARYLÁND Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or Itema 23a or 28a-f shov other traumatic event, Ite Medical Examinar must be notified at 1 X Yes 2 □ No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1804 N. BROADWAY 21213 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2☐ No If Yes, Give^X Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Never Married 🏖 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done du life. DO NOT use retired) during most of working permit. Pages 1 and 2 should be filled within: Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "rany injury or other traumatic event." Elementary/Secondary (0-12) College (1-4or 5+) FLOORTECH 11THJANITORIAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) THOMAS PETERSON CLARA THOMAS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LELLIAN MYERS (WIFE) 2012 RUSSELL AVE, BALTO, NO. 21207 APT. Bl 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State MT.ZION CEM. * 4 □ Denation 5 □ Other (Specify) OCT. 29,2004 BALTIMORE,MD. Sor ature of Funeral Service Licensee CALVIN AGUES SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTIMORE, MD. 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPTIC Physician SHOCK disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner COMMUNITY ACQUIRED PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ STAGE LIVER 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? Yes 2 No 1 Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည this 27. Manner of Death 1 Natural Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Tigs Certifying Priystorian. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES 000 OCTOBER MO 2004 30. Name and address of person who completed gause of death (Item 23a) (Type, Print) 600 NOTTH WOLFE STREET JOHNS HOPKINS HOSPITAL BALTIMORE MD 21287 SPIVAK 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar OCT 2 9 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie of 34471 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year 2:25 P M 25, Pau1 /Medical Hood Tart October 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 908 Monte Avenue Fallston Harford If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1525M 2□ F Director 239-28-7155 9, 1921 North Carolina Usual Residence of Decedent Show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ust be nutified at 1 ☐ Yes 2 No Director Maryland Harford Fallston 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 908 Monte Avenue 21047 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married Married 2 No ŏ Maryland 21215-0036 1 ☐ Yes 2/2 No Specify: the Medical Exam Be Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Cabinetmaker U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) es 1 and 2 should be fiill of Health and Mental H I Item 27 Is marked oth r other traumatic even D. Tart Jasper 2 Eunice (nmn) West 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a If item 27 Is or other trans 908 Monte Avenue, Fallston, Maryland 21047 Gertrude Tart / Wife Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 Degurial 2 Cremation 3 Removal from State Department of Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Highview Memorial Grdns 10-28-04 Fallston, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature #f,Funeral Service Licensee 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complibations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Physician Prostate Liears /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Physician/Medical as the t IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No tallure 3 ☐ Probably 4 ☐Unknown 1 Yes Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? director, page 2: 2 🗆 No 1 Tyes NA Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify)
t 28d. Describe how injury occurred P filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of After or Attending Natural 2 Accident Injury 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

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(Check only one)

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

auron

NANCY A. DAWSON MD 31. Date filed (Month, Day, Year) OCT 2 9 2004

32 Registrar's Signature

University of Maryland 225, Greene St. Baltimore

Maryland D31586 October 26,2004

29d. Date signed (Month, Day, Year)

Registrar

			1 - For State Registrar	State of Maryland / Dep	artment of Health and Nertificate of Death	Mental Hygier	1004	34472
	D.		1. Decedent's Name (First, Middle, Las	()		2. Date of Death		3. Time of Death
	Physici /Medio		Eleanor.	S. Willis			24, 2004	3:16 AM
*	Examir	er	4a. Facility Name (If not institution, give Saint Joseph	Medical Center	4b. City, Town, or Location of Death		4c. County of Death Balt	imore
	Funeral Director		5. Social Security Number 6. Security Number 1 217-14-6056 1 Usual Residence of Decedent	ex 7. Age (In yrs. last birthday, Yrs.	Months Days Hours Min.	8. Date of Birth Month, Day, Yea	ary 6 Mar	place (State or Foreign http)
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	with the I	Direct	10e. Street and Number	orbad lane#21	10f. Zip Code	10g.	Citizen of What Cour	ntry?
	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23e or 28e-f show or other treumatic event, the Mcdral Examinar must be notified at	Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
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	and 2 Balth an m 27 Is		MrDonald	Willis 350	9 Hillsmere	Rd. Ral	to Md.	21207
Baltimore,	es 1 a of Hea fitem r othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	20b. Place of Dispo cemetery, cre-	osition (Name of matory or other place)	Date 20c.	Location - City or To	own, State
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Bai	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 Is any injury or other tree		21. Signature of Funeral Service Urcen:	Puss 2	2. Name and Address of Facility	ineral H	Mr. 212	16-
В			23a. Part1/Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death. Do not enone cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest.		Approximate Interval Between
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.O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and otge 2 should be detached for use as the burial-transit	Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal death 3 □	□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	nry Day Year
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Records,	e law requ has been je 2 shoul	plet	DIABETES MELLITUS	<u> </u>		24a. Was an autopsy	24b. Were auto	osy findings available inpletion of cause of
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Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		h (Check only one)		
	d is	. To	1 ☐ Yes 2 🛣 No 27. Manner of Death	1 Inpatient 2 ER/Outpatier 28a. Date of Injury 28b. Time of		me 5 Residence 28d. Describe how inj		')
o	th. : Afte	ıtion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No	Loc. Documento non III	ary occurred	
Division of	Hospitel or Attending I 24 hours after death. Funerel Director: After tely filled in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rura. (te)	l Route Number,
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			moth	1. tour	D 24034		0124/1)4
	U		30. Name and address of person who	empleted cause of death (Item 23a) (Type,	Print)		1 11	
ri i	1	to	31. Date filed (Month, Day, Year)	M. D. 7601 OSL 32. Registrar's Signature	ER DRIVE, TOWS	ON, MARYL	AND ELE	214
10	Sta	ne .	OCT 2. 9. 21	101 Vienera G	home Val			

			1 - For State Registrar	State of Maryla	nd / Departm <i>Certific</i>	ent of Health and ate of Death		2004	34473
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	Physic /Medi		Toreatha	White			Month	28 200	0.00 0.00 0.0
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В	Funeral Director			□M 2XF // //	Yrs. Mont			ary a 1	irthplace (State or Foreign Jountry)
	D D		Usual Residence of Decedent				Dec. 24,1	757 10	larylana
	with the Maryland a or 28a-f show Le notified at	_	10a. State 10b. County	10c. 0	City, Town or Location				10d. Inside City Limits
	he M.	ecto	Maryland N	At	Balt	more			1 Yes 2 No
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	items 23a	Funeral Director	11. Marital Status	12. Was Decedent Ever in	U.S. 13 Was De	cedent of Hispanic Origin?	Specify Ves or No-	14. Race · Arr	> //
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/lar	noutd be I Mental narked c	To B	James .	John Sor	1	Any	rie W	hito	
Maryland	2 sho and I is me		19a Informant's Name/Relationship (Type, Print) naughter	19b. Mailing Addr	ess (Street and Number or F	lural Route Number, Ci	ty or Town, State,	Zip Code)
	of Health of Health item 27 i		MS.Monica	Chaney	1436	Wilmer	Ct. Bal	to.Nd	,21217
Jore	permit. Pages 1 and 2 should be illed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is merked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examiner must be notified at ance.		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	Place of Disposition (I	Vame of or other place)	Date 20c	. Location - City o	r Town, State
Baltimore,	permit. Page Department o Important: If any injury or once.		* 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Liber			metery!"18	12004	lunda	IK,Md.
Ba	permit. Depart Import any inj		March	Y P	JOSE	and Address of Licility	Funera	1. Home	-2.21/
			23a. Part1/Enter the disease, or com shock or heart failure. List only	plications that cauted the dea	ith. Do not enter the m	ode of dying, such as cardia	c or respiratory arrest.	ito. IVId	Approximate
	Physician		Immediate Cause (Final disease or condition						Interval Between Onset and Death
	/Medical		resulting in death)	a. Due to (or as a conse		2 cancer			2 month
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Вох	eath certifi attending I for use as	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet		pregnancy		23d. Date of de	livery
-	The law requires that the death certif tte has been signed by the attending vage 2 should be detached for use as	Physiclan/M	1 Yes 2 No	4☐ Pregnant at time of o	death 5 Other			Month	Day Year
P.0	res that the igned by be detact		Part II. Other significant conditions co	ntributing to death but not re-	sulting in the underlying	cause given in Part I	23e Did tobaco	a usa contributo t	o the cause of death?
Vital Records,	puires n sign lld be	d by	, , ,	NOT		y daddo givoir ii r tarri.			robably 4 Unknown
00	s been s s should	olete					24a. Was an		utopsy findings available
Re	The lav	Completed					autopsy performed?	prior to death?	completion of cause of
ita		BeC	25. Was case referred to medical			26. Place of Dea	1 ☐ Yes 2 🐼	Vo 1 □ Yes	s 2 💢 No
of V	S S	70 1	1 165 2 2 140	Hospital: 1 ☐ Inpatient 2 ☐	EP/Outpatient 3□ [Other	lome 5 Residence	6 □Other (Spe	ocify)
		on:	27. Manner of Death 1 BNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how in		,,
Division	or Attending ifter death. Director: After in by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	One Blace of let At	М	1 ☐ Yes 2 ☐ No			
Ď		Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, factory)	ory, office	28f. Location (Street: City or Town, Sta	and Number or Ri ite)	ural Route Number,
	Mospital 24 hours a Funeral i	-	29a. Certifier 12 Certifying Phy	sician: To the best of my kno	owledge, death occurre	d at the time, date and place	and due to the cause	(s) and manner as	s stated
	To the Hospital within 24 hours and the Funeral I completely filled	edica	(Check only 2 Medical Exam	ner: On the basis of examina and manner stated.	ation and/or investigation	on, in my opinion, death occu	rred at the time, date a	nd place, and due	o to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	00 5	2	9c. License number		Date signed (Mont	
7				user MD		DC023617			3 2004
	h		30. Name and address of person who co	ompleted cause of death (Item 201 Each 1	n 23a) (Type, Print) リハンとよし	Penkway	Bellimore	, MD	21218
	Star Registra	-	31. Date filed (Month, Day, Year)	32. Roistrar's Signa	ture & A	a dal			

State

Registra

ANA RUSIO, MO

OCT 2 9 2004

31. Date filed (Month, Day, Year)

32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygier 0 0 4 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name /First_Middle_Last 2. Date of Death Physician 2004 WARNEKOW /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LEVINDALE HEBREW HOME BALTIMORE N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth Min. (Months Days Hours Min. 0C1 10, 1915 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1**∑**M 2□F 89 215-01-3413 Yrs Director MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland neal of Health and Mental Hygiene.
ans: If item 27 ie marked other than "natural; or items 23e or 28e-f ehow try or other transmiter could be not all of the Medical Exemples. 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be colified at 10d. Inside City Limits Director MD N/A BALTIMORE 1 ¥ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 3021 FALLSTAFF ROAD #307 21209 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PRINTER BALTIMORE SUNPAPERS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be HYMAN WARNEKOW PEARL ABRAHAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3021 FALLSTAFF ROAD #307 - BALTIMORE, MD 21209 NORMA WARNEKOW / WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: if any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) BETH TFILOH CEMETERY: 10/28/2004 WOODLAWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Preumonia Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) ician and burial-transit Cause (Disease or Injuly that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Be Completed by Physician/Medical phys use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No 4☐Pregnant at time of death Month Dav Year 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 🗌 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22 No Dysplagin 25. Was case referred to medical 1 Yes 2 No 1 Yes director 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Yes 2 🗹 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours at To the Funeral D completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 056508 2004 no 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5/190 Betredere ane mo 31. Date filed (Month, Day, Year) 32, Registrar's Signature State Registrar ACT 2 9 2004

WARNEKON,

		_	For State of Maryla	and / Depa <i>Ce</i> i	artment of He	alth and M eath		en 2004	34476
			Decedent's Name (First, Middle, Last)				2. Date of Death	1	3. Time of Death
ų	Physici /Medic		HAMMED A. ASHI	RU			Month OCTOBER	Day Year 22 2004	1.50 PM
d	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Lo	ocation of Death	OULUBIA	4c. County of Dea	
- 4			SOUTHERN MARYLAND HOSPITA	L	CLINTO	N		PRINC	E GEORGES
11	Funeral Director			rs. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, February	1954 9. Bir Ye <i>ar)</i>	thplace (State or Foreign ountry) ERIA
921	D .		Usual Residence of Decedent		1 1				
	show	_		City, Town or Lo					10d. Inside City Limits TX Yes 2 □ No
	Ba-f	cto	MD Prince George's	Larg					
	ith th	Director	10.6. Street and Number		10f. Zip Code		10	g. Citizen of What Co	ountry?
	ath v	ra	106 Swiss Gap Road	11.0	207		- 3 V N-	U.S.A.	rices Indias
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 Is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 [♣ Widowed 4 □ Divorced		Was Decedent of Hisp If Yes, specify Cuban, 1□Yes 2점 No	panic Origin? (Spe Mexican, Puerto P Specify:	city Yes or No- Rican, etc.)	Black, Whit	
Maryland 21215-0036	hour tural	pe pe	3 \(\Delta\) Year or Dates:	16a Dece	dent's Usual Occupation	00		6b. Kind of Business	
1 5-	n 72 n "na"	Completed	(Specify only highest grade completed)	(Give	kind of work done dur DO NOT use retired)		1g	OD. KING OF DUSINESS	maasty
12	withi ene. than	mo	Elementary/Secondary (0-12) College (1-4or 5+) 3 yrs	Nur				Private	
D	Hyg Othar ant,	BeC	17. Father's Name (First, Middle, Last)			8. Mother's Name	(First, Middle, M	faiden Sumame)	
<u>a</u>	ld be lental kad lc ev	To B	Alhaji Ayangbola Ashiru]	Raliatu	Ashiru		
ary	12 should be filed within "h and Mental Hygiene." I a markad othar than "raumatic evant, the Med	-	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street and	d Number or Rura	l Route Number,	City or Town, State,	Zip Code)
	and 2 seath ar n 27 la		Kola Sofola/Friend	9104	Ridge Woo	d Drive	Ft. Wasł	nington, M	aryland 20744
re,	otha otha			b. Place of Dispo	osition (Name of matory or other place)		ate 2	20c. Location - City or	Town, State
Ë	Pages nent of h int: If its iry or o		1 Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify)	Oyo Ceme		11/19	/04 o	yo Nigeria	a.
Baltimore,	permit. Pages 1 and 2 s Department of Health ar Important: If itam 27 la any injury or othar trau		21. Signature of Funeral Senice Licensee	22	2. Name and Address 474 Landov	of Facility J.]	B. Jenki Landove	ns Funera	1 Home d 20785
			23a. Part1. Enter the disease, or complications that caused the c						Approximate
1	Dhysisian		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	ADEN	DCARC ID H.	A ME	destroit 1	Danany	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) Due to (or as a con		"CHICINGIA)	אט זט ד	121060014 1	r rancone i	
	Examiner								
, 🏴		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	sequence of):					
V.1.	od ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events						
Ć,	exec n an ial-tr	Еха	resulting in death) Last Due to (or as a con	sequence of):					
8760,	cate be executed physician and the burial-transit	dicai	d						
9	ifficat g phy as th	(a)	=======================================						
Вох	The law requires that the death centiticate be executed tate been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant 1		Ectopic pregnancy			23d. Date of de	
	deatl	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Other (specify)			Month	Day Year
P.O.	that the de ned by the a detached t	hys	9 Unknown						
	signed det	by F	Part II. Other significant conditions contributing to death but not	resulting in the u	inderlying cause given	in Part I.		acco use contribute to	
rd	w require been sig	ed					1 ☐ Ye	s 2□No 3□P	robably 4 Unknown
Division of Vital Records,	aw requ is been 2 should	Completed					24a. Was ar autopsy	24b. Were a	utopsy findings available completion of cause of
Ä	The I	E					perform	ned? death? X No 1 ☐ Yes	
ta	an: rtifica	0	25. Was case referred to medical		2	26. Place of Death			
>	yaici is ce direc	To B	examiner? 1 Yes 2 No Hospital: 1 Inputient	2 ER/Outpatier	nt 3 DOA Other:	4 Nursing Hon	ne 5 🗆 Reside	nce 6 Other (Spe	ecify)
0	ng Ph ter th		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Yea	z8b. Time o	of 28c. Injury a Work?		28d. Describe ho	w injury occurred	
ioi	auth. or: Af he tu	atlo	2 Accident investigation		M 1 □ Ye	s 2 □ No			
Σį	r Att	tiffe	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - A building, etc. (Sp.	At home, farm, sta	reet, factory, office	2	28f. Location (Str City or Town	eet and Number or R , State)	ural Route Number,
	ital o irs aff al Di led in	Certification;							
	To the Hospital or Attending Phyaician: The lav within 24 hours after death. To the Funeral Director: After this certificate has completely tilled in by the tuneral director, page 2	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my 2 Medical Examiner: On the basis of examiner and manner stated.	knowledge, deat aination and/or in	th occurred at the time, ivestigation, in my opin	, date and place, a nion, death occurre	and due to the ca ad at the time, da	use(s) and manner a ite and place, and du	s stated. e to the cause(s)
	withii To th	ž	29b. Signature and title of certifier		29c. License r	number		d. Date signed (Mon	
			Manustons		248	3158	Q	CT 23, 20	Do
	15		30. Name and address of person who completed cause of death SISOM OSIA, 6192 OXON HILL		Print)			mo 207	
	Sta Regist	ate	31. Date filed (Month, Day, Year) NOV 1 - 2004 32. Registrar's S	ignature /	Sparks			,	
	riegisi	A I	MONT - 7004	/-	//				

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death

34477

Reg. No.

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day In Year Physician ASHER KICHARD October 78 ZOO /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Locetion of Death 4c. County of Deeth Examiner Millennium Nursing & Rehabilitation Center Ellicott City Howard 6. Sex 1 🖾 M 2 🗆 F If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 1//1952 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 231-62-5295 52 Director Virginia Usuel Residence of Decedent nit. Peges 1 end 2 should be filled within 72 hours efter deeth with the Meryland bertment of Health and Mental Hygiene. ortant: If item 27 is marked other than "naturel", or thems 23a or 28e-1 show injury or other traumetic event, the Medical Examiner must be notified at 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Funeral Director Columbia Md. Howard 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21046 7260 D Edenbrook Drive Apt.D1 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify:White Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 4yrs Elementary/Secondary (0-12) Sales Electronics 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Odell Asher Audrey Varnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5465 Hunting Horn Drive Ellicott City, Md. 21043 Keith Campbell 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State National Memorial Gardens 11/1/04 Arlington, Va. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility Harry H. Witzke's Family F. H. Inc. 21. Signature of Funeral Service Licensee MOO845 4112 Old Columbia Pike Ellicott City, Md. 21043 mare malb 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on eech line. Physician ETASTATIC SQUARMOUS (Ell Sken Canley Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner METAS TASES Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the deeth certificate be execu METASTASES Division of Vital Records, P.O. Box 68760, Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ofon AR 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Junknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Tes 2 110 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 3□ DOA 28e. Date of Injury (Month, Day Year) 27. Mennes of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after deeth.

To the Funerei Director: Al
completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No. 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) October 29 7004 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) 34 SOO ArmoRy SUITE 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State NOV 1 .. 2004 Registrar **DHMH 16 Rev 6/95**

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2004 34478 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death BLANCHARD Day Year **Physician** HARRY 26 2004 3:32P M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Glen Burnie North Arundel Hospital Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Yeer) 07/10/1921 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1**X**M 2□F Director 83 217-12-5194 MD Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral, or items 23s or 28s-f show Examiner must be notified at 1 ☐ Yes 2 No Directo Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 225 Dale Road 21122 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ★Yes 2 □ No 194 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Marned 1943 Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🖔 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced 1946 "natural", Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Sheet Metal Worker U.S. Coast Guard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be le marked ပ Harry Columbus Blanchard Mary Helen Doneski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) itam 27 I Jean Blanchard/Wife 225 Dale Road, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If its
any injury or ot
once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/29/04 * 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, MD MD Veterans Cem 21. Signature of Funeral Service Licensee 22. Name and Address of Facility G.J. Gonce Funeral Home, PA 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death RENAL Immediate Cause (Final disease or condition FAILURE **Physician** HRS. resulting in death) /Medical Due to (or as a consequence of) Examiner DEHYDRATION fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, G.I. BLEEDING, 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No OSTEOMYELITIS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an OLD 1 Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death | Director: / d in by the f 2 Accident 6 ☐ Could not be 3 🔲 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft To the Funeral Di completely filled in 29a Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 029873 10/27/2004 Hending CRAIN HWY THEO GLEN BURNIE, MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
RITA PHANDS LWAL HD 1606 14 RHANDELWAL HD 1600 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

/Medi	ian	DOROTHY CARLIN	**) BAUER TX		TWITTE DATE	- TD	2. Date of Do	Day Yea	
Exami		4a. Facility Name (If not institution, give		OROTHY CO		vn, or Location of De	October	4c. County of De	11:06A
		1055 West Joppa F	Road		Tows	on		Baltim	
Funeral Director		5. Social Security Number 129–14–0732 6. Security Number 129–14–0732	DM 000	ge (In yrs. last birth	Months D		lin. (Month, D.	nth ay, Year) 15,1923 AI	lirthplace (State or Foreig Country) .abama
natural', or Items 23a or 28a-f ehow dical Examinst must be notified at	ctor	10a. State 10b. County Maryland Baltimo	re	10c. City, Town					10d. Inside City Limit
3 or 28 De Do	Funeral Director	10e. Street and Number	\l		10f. Zip Co			10g. Citizen of What (
ns 23.	eral	1055 West Joppa R	12 Was Decedent	Ever in U.S.		of Hispanic Origin?	(Specify Yes or No	USA	nerican Indian,
ral', or Iter Examiner	b	1 ☐ Never Married 2 ☐ Married 3 ★ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2XX If Yes, Give Year or Dates:	No	If Yes, specify	of Hispanic Origin? Cuban, Mexican, Pu No <i>Specify:</i>	erto Rican, etc.)		
	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or :		fe. DO NOT use re	one during most of v stired)	working	16b. Kind of Busines	•
Hygiene. ither than " int, the Me		17. Father's Name (First, Middle, Last)	2		Homemake		lama (First Middle	Own H	lome
and Mental Is marked o aumatic eve	To Be	Lester Woodbridge				Dor	een Greer	naway	
n 27 Is n		19a. Informant's Name/Relationship (7) JANET BAUER Janer Bauet Hartm	ypa, Print) IAN					er, City or Town, State, /land 21204	
of Health fitem 27 r other tra		20a. Method of Disposition 1 □ Burial XXCremation 3 □		20b. Place of D	isposition (Name of crematory or other	f place)	Date Date	20c. Location - City of	
		`4 Donation 5 □ Other (Specify)		ount Ceme	tery 11/		Baltimore,	
Department Important: Pany injury o		21. Chature of Funeral Service/Licens	a Kens	ekis .		6500 Yo	ork Road Bai	defeld Funera Itimore, Mary	
nysician	9 TY	23a. Part1. Enter the disease or comp shock, or heart failure. List only of Immediate Cause (Final	plications that caused one cause on each li	the death. Do not ne.	/			rrest,	Approximate Interval Between Onset and Death
Medical	П	disease or condition resulting in death)	aDue to (or as	a consequence of)	6/2050	Conce			154Rar1
xaminer									7
	- I	Sequentially list conditions,	b. —						
Insit	miner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		a consequence of)					
an and rial-transit	Examiner	Cause (Disease or injury	Due to (or as	a consequence of)					
ohysician and the burial-transit		cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as						
iding physician and ise as the burial-transit	edical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as c Due to (or as d	a consequence of)					
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4 hours after death. Funeral Director: After this certificate has been signed by the attending t ely filled in by the funeral director, page 2 should be detached for use as	edical Certification; To Be Completed by Physician/Medical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as c. Due to (or as d	a consequence of) of pregnancy 2 Fetal death time of death ut not resulting in the ont 2 ER/Outpa ry Year) 28b. Tim Inju ury - At home, farm c. (Specify) of my knowledge, d examination and/outed.	3 Ectopic pregna 5 Other (specify e underlying cause tient 3 DOA e of 28c. In y M street, factory, offi eath occurred at the r investigation, in m	given in Part I. 26. Place of D Cther: 4 Nursing nury at Work? Yes 2 No ce	24a. Was autor performed to the courred at the time, of the course the courred at the time, of the course the c	Month obacco use contribute 1 Yes 2 No 3 P an 24b. Were a prior to death? 2 No 1 Yes one) Dence 6 Other (Spenow injury occurred Street and Number or R orange of the street and Number or R cause(s) and manner and date and place, and decelerated	Day Year to the cause of death? Probably 4 Unknown uutopsy findings available completion of cause of s 2 No pacify) fural Route Number, s stated. e to the cause(s)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death amuel 30 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Long View Nursing Home Manchester If Under 24 Hrs. 8. Da Hours Min. (M Carroll 5. Social Security Number If Under 1 Year 6. Sex 1. XM 2. □ F 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 239-26-3668 82 Yrs. May 17, 1922 North Carolina Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits n/a Maryland Baltimore 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1627 Parkman Avenue 21230 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Subcontracting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel Birdsong Ellen Hudson

Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health, and Mental Hygiene. Important: If item 27 is marked other than "neturel", or items 23e or 28e-f. show piny jointy or other traumatic event, the Medical Examinat must be nutified at once. Baltimore, Maryland 21215-0020

Physician

/Medical

Examiner

Funeral Director

Be Completed by

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10a. State

Funeral

Director

Physician /Medical Examiner

physician and s the buriel-transit as esn ٥ been signed by the e should be deteched After this certificete has be funeral director, page 2 s within 24 hours efter death.

To the Funerel Director: After this certific completely filled in by the funeral director, To the Hospital or Attending I within 24 hours efter death. To the Funerel Director: After

The law requires that the death certificete be executed

Division of Vital Records, P.O. Box 68760,

Medical

29b. Signature and

30. Name and addres

31. Date filed (Manth Day)

0111111111111				Rural Route Numb	er, Only or rowr	n, State, Zip Cod	<i>0)</i>
Olivia Martin / Da	ughter		iontown Road				
20a. Method of Disposition	20b.	Place of Disposition (A cemetery, crematory of	ame of	Date		- City or Town,	
1 ABurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		adowridge M		11/2/04	Elkrid	lge, Mar	vland
21. Signature of Funeral Service License			and Address of Facility	Jubbard F	uneral	Home Tr	2
	12	4107	Wilkens Aver	nue, Balt	imore,	Maryland	2122
23a. Part1. Enter the disease, or complete shock, or heart failure. List only be	cations that caused the dealer cause on each line.					App	roximate val Between et and Death
Immediate Cause (Final disease or condition	The	tast	toc Cun	Com	cur	- 1	rear
resulting in death)	Due to (or as a consequence of):	1		1	
b)			1			
Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):				
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	. —						
resulting in death) Last	Due to (d	or as a consequence of	:				
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Part II. Other significant conditions con-	tributing to death but not res	sulting in the underlying	cause given in Part I.			ontribute to the o	
Part II. Other significant conditions cont	tributing to death but not res	sulting in the underlying	cause given in Part I.	24a. Was a	68 2 No	3 Probably 24b. Were au available	4 ☐ Unkno
Part II. Other significant conditions cont	tributing to death but not res	sulting in the underlying	cause given in Part I.	24a. Was a perfor	en autopsy	3 Probably 24b. Were au available completi of death?	4 ☐ Unkno
25. Was case referred to medical examiner?		sulting in the underlying		24a. Was a perfor	an autopsy med?	3 Probably 24b. Were au available completi of death?	4 ☐ Unknotopsy findings prior to on of cause
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25. Was case referred to medical examiner?		I ER/Outpatient 3□ D	26. Place of Do	24a. Was a perfor	an autopsy med? es 2 No ne) ence 6 □Oth	3 Probably 24b. Were au available completi of death? 1 Yes	4 ☐ Unknotopsy finding prior to on of cause

29c. License number

233165

29d. Date signed (Month, Day, Year)

DHMH 16 Rev 6/95

State Registrar

			1 - State of State of Registrar	Maryland / Depa	rtment of He	ealth and Me Death			34481
	Physici	an	Decedent's Name (First_Middle_Last)				Reg. 2. Date of Death Month	Day Year	3. Time of Death
	/Media	cal		Gardener		(october	27 2006	/
	Examir	ner	4a. Facility Name Affoot institution, give street and num Future Care Dryin	aton	4b. City, Town, or Balti			4c.County of Death Baltimore	
	Funeral	Г	5. Social Security Number 6. Sex 7	Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. 8	L Date of Birth (Month, Day, Ye	9. Birth	place (State or Foreign
	Director		214-22-1919 1□ M 2\ X F Usual Residence of Decedent	78 Yrs.			Sept. 28.		ryland
	ryland show		10a. State 10b. County	10c. City, Town or Loca	ation				10d. Inside City Limits
	the Ma 28e-1 c	ecto	MD Baltimore City 10e. Street and Number	Baltimore	T				1X Yes 2 ☐ No
	3e or	Funeral Director	442 South Smallwood St.		10f. Zip Code 21223			Citizen of What Cou	intry?
	ter deat	iner		lent Ever in U.S. 13. W		spanic Origin? (Speci , Mexican, Puerto Ri		14. Race - Ameri	
36	be filed within 72 hours after death with the Maryland hal Hygiene. Id other then "neturel", or Items 23e or 28e-1 ehow event, the Medical Ever in sermant by notified at	by Fu	1 Never Married 2 Married 1 Yes, 2 If Yes, Give Year or Dal	X (XNo	Yes 2 XNo	Specify:	can, etc.,	Black, White,	
21215-0036	2 hou	ted t	15. Decedent's Education	16a, Decede	ent's Usual Occupat	tion	16b.	Kind of Business/Ir	
121	within 7 ene. then "r	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-	40I 5+)		uring most of working			
d 2:	filed with Hygiene other theo		12 –	House		18. Mother's Name (i		ousewife	
/lan	should be ind Mental marked o	To Be	Frank Beefelt			Eleanor		J. Odinanoj	
Maryland	nd 2 she lith and 27 le m r treum		19a. Informant's Name/Relationship (Type, Print) Bruce Baumgardner/Son	19b. Mailing 610 B	Address (Street ar	nd Number or Rural F Rd., Balt	Route Number, City imore, M	or Town, State, Zij D 21229	p Code)
Baltimore,			20a. Method of Disposition 1 □ Burial 2 【XCremation 3 □ Removal from Si	20b. Place of Disposition cometery, crema	ition (Name of atory or other place,	Dat	e 20c.	Location - City or To	own, State
ţim			* 4 ☐ Donation 5 ☐ Other (Specify)	National	Cremator	y 11-1-2	004 Fa	lls Churc	h, Virginia
Ba	permit. Departr Imports any inju		21. Signature of Funeral Service Licensee	7.	Name and Address 36 Edmond	lson Ave.	ling Ash Baltimor	on Schwa	28 ^{F. H.} Inc
			23a. Part1. Enter the disease, or complications that cal shock, or heart failure. List only one cause on ear						Approximate Interval Between Onset and Death
	Physician /Medical		resulting in death)	roschroti	c (grd	iovasa	clar di	Sease	4 ears
P	Examiner			r as a consequence of):					Uears
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	axecuti and al-tran	Examin	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or	as a consequence of):					
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	ertifica fing ph		IF FEMALE:						
Вох	death certific	Physiclan/M	in the past 12 months?		Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
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	es on pe	by	Part II. Other significant conditions contributing to dea	h but not resulting in the und	derlying cause given	in Part I.		o use contribute to the	
ecords,		Completed					24a. Was an		ppsy findings available
α	0 T 0	ошо					autopsy performed? 1 ☐ Yes 2 ☑ N	prior to cor death?	mpletion of cause of
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?			26. Place of Death (C		0 , 163	24 110
of	Phys r this ral dii	. To	1 ☐ Yes 2 ₹ No Hospital: 1 ☐ Ing 27. Manner of Death 28a. Date of		3 □ DOA Other:	4 Nursing Home	5 Residence	6 Other (Specify	y)
ion	Attending Phi ir death. ector: After thi by the funeral o	atior	1 Natural 5 □ Pending (Month, 2 □ Accident investigation	Day Year) Injury	Work?	es 2 No	. Bestine flow in	ary occurred	
Division	l or Atte after de Directo I in by th	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place or building	f Injury - At home, farm, stree , etc. (Specify)	et, factory, office	28f.	Location (Street a City or Town, Sta	and Number or Rura te)	I Route Number,
	spital		29a. Certifier 15 Certifying Physicien: To the b	est of my knowledge death o	occurred at the time	date and place, and	due to the cause/	c) and manner on al	talad
	To the Hospital or Attend within 24 hours after deatt To the Funeral Director: completely filled in by the	edical	(Check only 2 Medicel Examiner: On the bas one)	is of examination and/or inves	stigation, in my opin	nion, death occurred	at the time, date a	nd place, and due to	the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	24.5	29c. License r	5503		ate signed (Month, I	
•	n		Amatun M Macon			3003	1 06	Tober, 2	-8,2004
	1)	1	30. Name and address of person who completed cause AMATUN N MAE	EM 501	DOLPHI	1			
	Sta Registra		31. Date file (194) Pay Y2004	istrar's Signature	DOLPHI DOLPHI				

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Physicia /Medica Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical

been signed by the attending physician and should be detached for use as the burial-transit 2

Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 of completely filled in by the funeral director.

Division of Vital Records, P.O. Box 68760,

•	1 - State C	ו Maryland / ט י	cepartment of H Certificate of I	leaith and iv D <i>eath</i>	ientai Hygie Reg.		34482				
	Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Yea	3. Time of Death				
	Jong Soon Byun				October						
r	4a. Facility Name (If not institution, give street and nu	mber)	4b. City, Town, or	Location of Death		4c. County of De					
	Gilchrist Hospice		Tows			Baltimo					
	5. Social Security Number 6. Sex	7. Age (In yrs. last birt)	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	9. E	hirthplace (State or Foreign Country)				
}	412-02-8486	68 Y	rs.		Sept.5,	1936 Sc	outh Korea				
}	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits				
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recto	MD Howard 10e. Street and Number	Fill	icott City 10f. Zip Code	/	10g.	Citizen of What	Country?				
בַּ	2020 Green Chede Co		2104	,	S	South Korea					
Funeral		edent Ever in U.S.	13. Was Decedent of H			14. Race - Ar	merican Indian,				
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2	X₂X Widowed 4 □ Divorced If Yes, G Year or D	Dates:	ILLIES ALANO	Specify: KC	orean						
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o Re	17. Father's Name (First, Middle, Last)										
- Mydrig nee Kim											
	19a. Informant's Name/Relationship (Type, Print)		and the Table			5 1000	Test				
	Tim Clemons 20a. Method of Disposition	20b. Place of	20 Green ! Disposition (Name of		Date 200	L1COLL :. Location - City	CITY, MD or Town, State				
	XXBurial 2 ☐ Cremation 3 ☐ Removal from	State	v, crematory or other place		28/04 M	arriott	errillo MD				
	^4 □ Donation 5 □ Other (Specify) Crestlawn Cemetery 10/28/04 Marriottsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Witzke Funeral Homes, Inc.										
	Marbell the						a, MD 21045				
	23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	caused the death. Do n					Approximate Interval Between				
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	Immediate Cause (Final disease or condition resulting in death) a. MCTGSTATIC POLICICAL Caucas Due to (or as a consequence of):										
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ician/M	in the past 12 months?	birth 2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of d Month	Day Year				
ysic	1 ☐ Yes 2 ØNo 9 ☐ Unknown		5 Cirier (specify)								
7	Part II. Other significant conditions contributing to contribu	death but not resulting in	the underlying cause give	en in Part I.	23e. Did tobac	co use contribute	to the cause of death?				
d by					1 ☐ Yes	2 № 3 □	Probably 4 Dunknown				
eted					24a. Was an	24b. Were	autopsy findings available				
Comp					autopsy performed 1 ☐ Yes 2 🔀	prior t death	o completion of cause of				
ပ် မ	25. Was case referred to medical			26. Place of Deat	1 Yes 2 A	No 1 Y	es 2 No				
0	examiner? 1 Yes 2 No Hospital: 1	Inpatient 2 ER/Out	patient 3 DOA Oth	0.5	me 5 Residence	6 Other (Sp	pecifyHospice				
=	27. Manner of Death 28a. Date	of Injury 28b. T	ime of 28c. Injury	at	28d. Describe how i		, aloup Loo				
atio	2 Accident investigation	111, Say 7 Sai)		Yes 2□No							
3 Suicide 6 Could not be determined 5 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 5 City or Town, State) 28f. Location (Street and Number or Insurance Street and Number or Insurance Street and S											
Ce											
edicai Certification:	29a. Certifier 1 ✓ Certifying Physician: To the (Check only 2 ☐ Medicel Examiner: On the	basis of examination and	, death occurred at the tin For investigation, in my o	ne, date and place, pinion, death occurr	and due to the cause ed at the time, date	e(s) and manner and place, and d	as stated. ue to the cause(s)				
Med		nner stated.	29c. License	a number	29d	Date signed (Mo	nth Day Year)				
	29b. Signature and title of certifier	16/1				_					
	1110hopshi / Walat	16 ms	1) 3 d	504	Uc	TUDES C	- 1, alley				
	30. Name and address of person who completed cau	wy IIDIA	Li YYLL PATEL	YEUT PKIL	Columbia	MNZ	1044				
е.	31. Date filed (Month, Day, Year) 32.	Registrar's Signature			-v [www]IV	4 77.10	/				
r	NUV 1 - 2004 A	genera	9 Sports	/							

State Registrar

books

State of Maryland / Department of Health and Mental Hygier 004 34483 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Bernadette L. Buzgierski October 23, рм 2004 7:42 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bayview Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 ☐ M 2 🖾 F 212-34-3861 Director 67 Sept.28,1937 Maryland Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "netural", or Items 23a or 28e-f show the Medical Examiner must be notified at Director 1 to Yes 2 □ No n/a Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 6600 Marne Ave. 21224 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married ☐ Yes 2 No f Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 ™ Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked othe eny injury or other treumetic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Casimir Ziemski Anna Gorczewicz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Buzgierski/son 6600 Marne Ave., Baltimore, Md. 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Service Corp 10/25/04 4 Doffation 5.☐ Other (Specify) Towson, Md. ice License 21. Signal re of Fune al St 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd., Towson, Md. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 2 months Dilated Cardiomyopathy /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physiclan/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2X No 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.0. 9 Unknown þ signed by the period of the period of the details and the details are the details and the period of Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X☐Unknown Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate Division of Vital 1 Yes 2 X No Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death Check only one) examiner? Hospital: 1 ☐ Inpatient 2 🗷 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🔀 No 3 DOA this After this 28a. Date of Injury (Month, Day Year) 27, Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pendina death. 2 Accident investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D16960 October 25, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1576 Merritt Blvd. Baltimore, Md. 21222 F.E.Chatham, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar - 2004

State of Maryland / Department of Health and Mental Hygiene on the

			Registrar AMEND ITEM #1 PER ME G83/	1 £	artment of Health and Diffcate In Death	Reg. N	10.
	Physici /Medio		1. Decedent's Name (First, Middle, Last) -Willa WILLE MAE	ROOKS	5		3. Time of Death 21 - 2004 11 • 05 a
4	Examir		4a. Facility Name (If not institution, give street and number) 1216 NORTH MILTON AVENUE		4b. City, Town, or Location of Deal BALTIMORE CITY		21, 2004 11:05a "" c. County of Death NA
I	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last 1	birthday) Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth Month Day Yea 8-23-52	9. Birthplace (State or Foreign Country) N.C.
	ow II		Usual Residence of Decedent 10a. State 10b. County 10c. City, T.	own or Lo	cation		10d. Inside City Limits
:	a-fsh	tor	Md. NA	Bal	timore		Y Yes 2 No
7	In with the 23s or 28 Ist be no	ai Director	10e. Street and Number 1216 N. Milton Ave.		10f. Zip Code 21213	10g. C	Sitizen of What Country? USA
036	should be lied within 72 hours atter death with the Maryland Ad Mental Hygiene. The marked other than "natural; or itema 23a or 28a-f show marked other than "natural; or item 23a or 28a-f show matic event, the Medical Examiner must be notified.	by Funerai	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Vas Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puer ☐ Yes 2【 No Specify:	pecify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
Maryland 21215-0036	within 72 ho ene. than "natur he Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+)	(Give I life. L	ent's Usual Occupation kind of work done during most of wo DO NOT use retired) abled	rking	Kind of Business/Industry
מ	other	Be Co	17. Father's Name (First, Middle, Last)	515.		ne (First, Middle, Maide	
ylar	should be ind Mental i marked o umatic eve	ToB	Willie Vandrus			ise	Mott
Mar	7 is		19a. Informant's Name/Relationship (Type, Print) Lee Mason Son		g Address <i>(Street and Number or Ri</i> N. Kresson Street		
_	Heal Heal Bm 2 ther		20a. Method of Disposition 20b. Place		sition (Name of latory or other place)		ocation - City or Town, State
<u> </u>	rages ment of l ant: if its ury or o		L Dunal E Continuation o Citiento and in State			L-04 Bai	ltimore, Md.
Baltimore,	permit. Pag Department Important: if any injury o		21. Signature of Funeral Service Licensee BLMON D 30 MWW		Name and Address of Facility arch F.H. East	Baltimon 1101 E. No	
E .	/Medical by specifical physician and physician and physician and street physician street ph	edical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e ul).	minedefici	erey y	Onset and Death
C. BOX	by the attending placehold for use as t	hysiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dead 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
ecords, P	should be deta	ру Р	Part II. Other significant conditions contributing to death but not resulting	j in the un	derlying cause given in Part I.		use contribute to the cause of death?
T	ate h page	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 \[\text{Yes} \] 2 \[\text{No} \]
Or Vital	is certific	o Be	25. Was case referred to medical examiner? 1 X ves 2 □ No Hospital: 1 □ Inpatient 2 □ ER/6	Dutnatient		th (Check only one) ome 5 A Residence	6 Other (Secrital)
	fter	ation: T		. Time of Injury	28c. Injury at Work? M 1 Yes 2 No	28d. Describe how inju	
DIVISION 191	within 24 hours after death. To the Funeral Director: Completely filled in by the funeral properties of the funeral prope	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, stre	et, factory, office	28f. Location (Street ar City or Town, State	nd Number or Rural Route Number, e)
HOSO	Funer Funer tely fill	edicai	29a. Certifier (Check Say Medical Examiner: On the basis of examination one)	ge, death and/or inve	occurred at the time, date and place estigation, in my opinion, death occu	and due to the cause(s) and manner as stated. d place, and due to the cause(s)
Tothe		Mec	29b. Signature and title of certifier		29c. License number OCME		te signed (Month, Day, Year) BER 22, 2004
	3		30. Name and address of person who completed cause of death (Item 23a		rint) 1 Penn Street, B	altimore, M	aryland 21201
	Sta Registra		31. Date filed (Month, Day, Year) NOV 0 3 7004 32. Registrar's Signature	4	1		

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygien® O. O. I.

			AMEND ITEM #16a PER FH G837 11/01/Petifinate of De		al Hygien Reg. No		4485
	Physici	an	1. Decedent's Name (First, Middle, Last) Sallie Doswell Blackwell		ate of Death Ionth Da	3.	Time of Death
No.	/Medic Examir	al	4a Fecility Name (If not institution, give street and number) 4b.	. City, Town, or Location	of Death 4c	. County of Deeth	2.00 PM
4				llicott C	ity	Howard	
Ċŧ.	Funeral Director		230 – 38 – 8503 1	If Under 24 Hrs. 8. Da Hours Min. (M Au	ate of Birth fonth, Day, Year)	9. Birthplace Country) 1916 Virg	(State or Foreign inia
	ylend wor		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Ir	nside City Limits
	he Mar 28a-f si ortified	ector	Maryland Howard Ellicott City		1 □ Yes X □		
	h with t	al Dir	10e. Street and Number 4714 Wigglesworth Court 21043		10g. Cit	tizen of What Country? USA	
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Heath and Mental Hydiene. Department of Heath and Mental Hydiene. Intropretant: If them 27 is marked other than "naturel", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Funer	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No	panic Origin? (Specify Y Mexican, Puerto Rican, Specify:	'es or No- , etc.)	14. Race - American In Black, White, etc. Specif Black	dian,
2-0	natur Nicel	eted	15. Decedent's Education (Specify only highest grade completed) Florendary(Specify only highest grade Completed) Florendary(Specify only highest grade Completed) Florendary(Specify only highest grade Completed)	on ring most of working		ind of Business/Industry	
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Maryland 21215-0020	ild be filec lental Hyg ked other ic event,	To Be C		8. Mother's Name <i>(First</i> Sallie Li			
Mary	2 should and Men is marks reumetic		19a. Informant's Name/Relationship (Type, Print) Gerald Blackwell/ Son 4714 Higgslock	d Number or Rural Rout	te Number, City o	or Town, State, Zip Code	, 21043
	: 1 and Health tem 27 other tr		471 Wiggles				
OE .	Pages nent of I int: if Ite iry or o	- 1	20a. Method of Disposition 1XI Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) New Prospect Bar	ptist Ch.	Cem.B	lackstone	, Va
Baltimore,	permit. Departr Imports any Inje		21. Signature of Funeral Service Licensee 22. Name and Address of 5 2 4 0 Reiste	of Facility Chatm erstown R	an-Har	ris Funer imore, Md	al Home 21275
	5530		23a. P. 11. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, s shock, or heart failure. List only one cause on each line.	such as cardiac or respi	iratory arrest,	Appr	oximate val Between
	Physician /Medical		Immediate Cause (Final disease or condition CEREBRAC 74)	HROMBOS	213	Onse	et and Death
, E	Examiner	_	resulting in death) a Due to (or as e consequence of):	,, 0, ,,,,,			
	uted	edical Examiner	Sequentially list conditions. Due to (or as e consequence of):				
o,	ficate be executed physician end is the buriel-transit	EX	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events Due to (or as a consequence of):				
68760,	= 0, 4		that initiated events resulting in death) Last Due to (or as a consequence of):				
Box	es that the death certifics igned by the attanding pt be datached for use as the	lan/N	d				
o	the de yy the a ached t	hysic	Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in	in Part t. 23		usa contributa to tha c	
ς Σ	es that igned b	by P	DUSPHAGIA		1 Yas 2	□ No 3□ Probably	4 Donknown
Vital Records,	requir been s should	Completed by Physician/N		24	ta. Was an autop performed?	available	on of cause
	ining Pnysician: the law h. Affer this certificata has funeral director, page 2	ခ် မြ			1 □ Yes 2.	No 1 □Yes	2 □ 1√0
<u> </u>	sician certifi lirector	To Be	examiner:	6. Plece of Death (Chec		Положения	
0 .	ng Phy terthis neral o	ü	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 2 Natural 5 Pending 28b. Month, Day Year 28b. Time of 28c. Injury at 28b. Natural 28b. Time of 28c. Injury at 28b. Time of 28c. Injury at 28b. Time of 28c. Injury at 28b. Time of 28c. Injury at 28b. Time of 28c. Injury at 28b. Time of 28c. Injury at 28b. Time of 28c. Injury at 28b. Time of 28c. Injury at 28b. Time of 28c. Injury at 28b. Time of 28c. Injury at 28b. Time of 28c. Injury at 28b. Time of 28c. Injury at 28b. Time of 28c. Injury at 28b. Time of 28c. Injury at 28b. Time of 28c. Injury at 28	4 Nursing Home 5 28d. De	escribe how injur		
UNISION	eat the	catic	2 ☐ Accident investigation M 1 ☐ Yes 3 ☐ Suicide 6 ☐ Could not be	s 2□No			
2	o the nespital or attending the nespital or attending the funeral Director: Impletaly filled in by the	Certification:	determined 4 ☐ Homicide 28e. Place of trijury - At home, farm, street, factory, office building, etc. (Specify)	Z81. Lot Cit	y or Town, State,	d Number or Rural Rout }	s Number,
	Hospi 4 hou Funer taly fil		29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, description of the death occurred at the deat	date and place, and due on, death occurred at the	e to the cause(s) ne time, date and	and manner as stated. place, and due to the c	ause(s)
	within 2 To the		29b. Signature and title of certifier 29c. License nu		29d. Date	e signed (Month, Day, Y	'ear)
	•		Jasneun Yallam 1283	121-	10	122/04	
	<i>p</i>	-	Jasueu Lallau D283 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TASNEEM AKHAM, 7220 APK	HEICHTS	ArE,	BAIRM	1) 2120 F
	Stat Registra	e	31. Date filed (Month, Qay Year). 32. Registrar's Signature				

State of Maryland / Department of Health and Mental Hygienes For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** BRIDDELL 2004 WILLIS H . October 27, 11:03 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Crisfield

If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)

March 28, 1919 lll Hall Highway Somerset Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Months Days 1⊠M 2□F 85 Yrs Marylánd Director 215-05-7046 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show Item 27 is marked other than "neturel", or Items 23a or 28a-f show other traumatic event, the Mydical Exprintment at 1X Yes 2 □ No Directo Crisfield Maryland Somerset 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with lll Hall Highway 21817 Completed by Funeral IISA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 XYes 2 No World 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No White Specify: Specify: 3 Widowed 4 Divorced Year or Dates: War II 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Commercial Real Estate Elementary/Secondary (0-12) College (1-4or 5+) 12 Broker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be f Health and Menta Item 27 Is marked Charles D. Briddell Gracie Mae Maddox 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8002C Dollyhyde Road - Mt. Airy, Maryland 21171 Kent Briddell (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ö permit. Page Department o Important: If any injury or Sunnyridge Memorial Park Oct. 31, 2004 Crisfield, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses

Mary Beth Bradshaw-Pruitt 22 Name and Address of Eacility
Bradshaw & Sons Funeral Home 306 W. Main Street - Crisfield, Maryland 21817 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mods of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ASCVD Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9 Unknown 9 Unknown Š 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. should be 2 X No 3 Probably 4 Unknown 1 Yes peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy performed certificate 1 Yes 2 No in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Statement 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To 1 Tes this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation To the Hospital or Attending 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No death. within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D48098 October 29, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vijay Karumbunathan, M.D. - 201 Hall Highway - Crisfield, Maryland 21817 32. Registrag's Signature State 2004 Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2004 34

			AMEND TTEM	C#1 PER	PHY C837	11/10	108	rtifica	te of	Death		Reg. No.	U4	3441	81
	Dhusisi	an	1. Decedent's Neme (First, Middle, La	st)						2. Date of De	eeth Day	Year	3. Time of Dea	
1	Physici /Medio Examir	al	Dolly Vig				inia	Brown		4b. City, Town, or	Oct 2	28, 2004		11:30	AM
	LXanın		Westminst	er Nursi	ing and Re	habil:	itati	on		Westmins	ter	Carro	1.1		
Ą	Funeral Director		5. Social Security Num 215-36-73	nber 6. S		e (In yrs. la 66			or 1 Year Days			rth ay, Year)			oreign
- 45	P .		Usual Residence of D	ecedent		10- 01-	Town and							Od toolds City I	:-:4-
	Maryler a-f ahow	tor	10a. State 1	Ob. County Carroll		Westr	Town or L ninst						10	0d. Inside City Li 1 ☐ Yes 2∑	
	or 28	Director	10e. Street and Numb	er				10f. Z	ip Code			10g. Citizen of \	What Coun	try?	
	23s	la L	726 Oak Ti	ree Rd.					21157			United	State	S	
Baltimore, Maryland 21215-0020	permit. Peges 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental hygiene. Department of Health and Mental hygiene important: if ten 27 is marked other than "natural", or items 23a or 28a-f ahow important: if ten 27 is marked other than "natural", or items 23a or 28a-f ahow all programments event, the Medical Exercities I must be notified at ance.	by Funeral	11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4		12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:		. 13	If Yes, sp	ecify Cub	dispanic Origin? (S an, Mexicen, Puert Specify:	pecify Yes or Note Rican, etc.)	Blac	ce - America ck, White, e y: Whi	etc.	
2-0	72 ho	eted	(Specify	5. Decedent's Ed	ducetion ade completed)		16a. Dec	edent's Us e kind of w	ual Occup ork done	oation during most of wor d)	rking	16b. Kind of B	usiness/Ind	Justry	
12	within ene. then r	Completed	Elementary/Second		College (1-4or	5+)				d)					
7	filed v Hygie other t	ပိ	8th 17. Father's Name (Fi	rst. Middle. Last.)		Hom	emake	r	18. Mother's Nar	ne (First, Middle	ner , Maiden Suman	home		
an	ental ked o	To Be	William Le	e Riley						Fannie 1	Lee Fraz	zier			
ary	should be and Mental marked o		19a. informant's Nam	e/Relationship (Type, Print)		19b. Mai	ing Addre	ss (Street	and Number or Ru	ural Route Numb	oer, City or Town,	State, Zip	Code)	
Σ	and 2 salth e n 27 is	- 11	Morris B.	Brown,	Sr. (Husb					Rd. West	tminster	, MD 21	157		
ore	of He of He f Rem	A.Y	20a. Method of Dispos		Removal from State	20b. Pla	ice of Disp metery, cre	osition (Na amatory or	ame of other pla	ce)	Date	20c. Location -	City or To	wn, State	
<u>E</u>	Peges ment of I ant: If Ite ury or o		4 Donation 5			s. c	Carro	11 Cr	emat	ory, P.A	. 11/2/2	004 Win	field	, MD	
Ball	permit. Departr importu any Inj		21. Signature of Fune	et Servicer Licer	1804		В	urrie	r-Qu	ess of Facility een Funet Old Libet				•	
			23a. Part 1. Enter the shock, or heart f	disease, or com	plications that caused one cause on each li	d the death.							1	Approximate Interval Between	ən
3	Physician				O	^					-		1	Onset and Deat	
1	/Medical Examiner		Immediate Cause (Fir disease or condition resulting in death)	nai	a level	w	Vu	sen	dr	acco	rolen	7		pmu	
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	uted d ansit	edicai Examiner	Seguestially list cond	itions	b. 1.4 N.C.	Due to (or a	-			roover		zem	1		
o,	rtificate be executed ng physician and set the bunal-transit	EX	Sequentially list cond if eny, leading to imm ceuse. Enter Underly Cause (Disease or inj	ediate ring		,							ì		
68760,	ate be hysici the bu	lica	that initiated events resulting in death) Las		C	Due to (or a	as a conse	quence of):				1		
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Вох	eath ce attendir I for use	jan			•										
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σ.	thet ned by deta	4									10	Yes 2 No	3 LI PIOD	ably 4 Oliv	KIOWII
Division of Vital Records,	requir been s should	Completed by							_			s an autopsy ormed?	ava	ere autopsy findi allable prior to mpletion of caus death?	-
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× >	Physic this ce ral dire	2	1 ☐ Yes 2 🛣 No)	Hospital: 1 Inpatie	100	-	ent 3□ C	NOA .			idence 6 □Oth		1)	
Ē	ing Pl	ü	27. Manner of Death	5 Pending	28e. Date of Inju (Month, Da	y Year) 2	28b. Time Injury		28c. Inju Wo		28d. Describe	how injury occur	red		
<u>s</u>	or Attending Physician: efter death. Director: After this certific i in by the funeral director,	Certification:	2 ☐ Accident 3 ☐ Suicide	investigation 6	e Ope Diese of les	una At hom	a farm c	M treet facto		Yes 2 □ No	28f Location	(Street and Numb	ner or Rura	l Route Number	r
2	Office Direction by	eri	4 ☐ Homicide	determined	building, et	c. (Specify)	10, 141111, 3	troot, racio	ry, onice			wn, State)	0, 0, 1,0,0	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	To the Hospital or Attending Physician: The I within 24 hours either death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edicai C	29a. Certifier 1 (Check only 2 one)	Certifying Ph	nysician: To the best niner: On the basis o and manner st	exemination	ledge, dea on and/or i	th occurre	d at the ti	me, date and place opinion, death occu	and due to the erred at the time,	cause(s) and ma date and place,	and due to	ated. the cause(s)	
_	o the	Me	29b. Signature and titl	le of certifier				2	9c. Licens	se number		29d. Date signe	d (Month, L	Day, Year)	
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	7		30. Name and eddres:	s of person who	completed cause of c	leath (Item 2	23a) (Type	, Print)	- 6	1945 le Rd,		, , , ,	1 -00		
	/		John	W. Y.	nidd(etoi	7 6	85	Poal	e Kd,	West	minster	r	MD2111	7
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State of Maryland / Department of Health and Mental Hygien 2001 34488 For State Registra Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Leroy Bennett October 28, 2004 3:30 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 8151 Bennett Branch Rd. Mt. Airy Carrol1 If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Yrs 212-26-3643 87 Maryland Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f ehow Exercitive mant be notified at 1 ☐ Yes 2 No Director MD Carroll Mt. Airy 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö or items 23a 8151 Bennett Branch Rd. 21771 United States death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filed within 72 hours atler nent of Health and Mental Hygiene. The restreed other than "naturel, or the nry or other traumatic event, the Mouldal Esser interry or other traumatic event, the Mouldal Esser interry or other traumatic event, the Mouldal Esser inte 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: Specify: Completed by 3 ☑ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Brown and Root 10th Carpenter 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Charles Edward Bennett Mary E. Majors 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8151 Bennett Branch Rd. Mt. Airy, MD 21771 Janice Bennett (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or injury c 4 ☐ Donation 5 ☐ Other (Specify) S. Carroll Crematory 10/28/2004 Winfield, MD 22. Name and Address of Facility 21. Signature of Funeral Se Burrier-Queen Funeral Home and Crematory, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| MID 2179 / Approxima e interval Between Onset and Death | Do not enter the mode of dying, such as cardiac or respiratory arrest, shock and Death | Do not enter the mode of dying, such as cardiac or respiratory arrest, shock and Death | Do not enter the mode of dying, such as cardiac or respiratory arrest, shock and Death | Do not enter the mode of dying, such as cardiac or respiratory arrest, shock and Death | Do not enter the mode of dying, such as cardiac or respiratory arrest, shock and Death | Do not enter the mode of dying, such as cardiac or respiratory arrest, shock are the mode of dying are the Immediate Cause (Final disease or condition resulting in death) Due to (or asys consequence of): **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as Examiner lor Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) attending physician Box 68760 Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 2 1No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 2 ER/Outpatient 3 DOA Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 1 Inpatient this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After t 5 Pending investigation 1 → Natural 2 □ Accident death. М 1 Tyes 2 No after death Director: the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funeral D Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) ţ 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 108 THOMAN JOHNSON 144 32. Registrar's Signature State 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene? 34489 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 4:45 рм Veronica Roland Oct. Brown 24, 2004 /Medical 4e. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Laurel Laurel Regional Hospital Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) August 10, 5. Social Security Number 9. Birthplace (State or Foreign Country) 1942 South Caroline 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🂢 F 62 042-34-9703 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or itame 23a or 28a-f show other traumatic event, the Michael Examiner must be notified at MD Prince Georges 1 Tyes 2 No Bowie Funeral Director 10e. Street and Number 6402 Grason Terrace 10f. Zip Code 10g. Citizen of What Country? 20715 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14. Race - American Indian, Black. White, etc. 1 Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married XXX Married Maryland 21215-0036 1 ☐ Yes 2 🗗 No Specify: African-American þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Verizon-Communi-cations Executive +5 permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg
Important: if Item 271s marked other
any injury or other traum..... 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Roland Myrtle Thompson Roland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melford George Brown/spouse 6402 Grason Terrace, Bowie, MD 20715 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 [X] Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 10/27/04 Beltsville, MD 5 ☐ Other (Specify) 21. Signature Funeral Service Lica see 22. Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Avenue Silver Spring, MD Farth. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Breast Cancer 6 years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Clease or in, in) that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical be detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2**X** No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2X No Certification: To M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred After 5 Pending investigation 1X Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide o the Hospital Certifying F hysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) October 25/2004 14501 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LAN RUE S 834 ISABLUL eno 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		1 - For State Registrar	State of Maryland / D	Department of Health and Certificate of Death		
N.	100	1. Decedent's Name (First, Middle, Las		Commodity of Bodin	2. Date of Death	3. Time of Death
	siciar edica		Crai	i Jr.		Day Year 342 PM
 Both College 100 	mine		street and number)	4b. Cily, Town, or Location of De	eath	4c. County of Death
The state of the s		Northwest	Hospital Cent			Baltimore.
Fune Direct		5. Social Security Number 6. Social Security Number 1.	مستر وسل ۱۳۰۰		In. 8. Date of Birth	9. Birthplace (State or Foreign Country)
	101	Usual Residence of Decedent			Duly a 1,	1727 NUFIN Carolin
rylan		10a. State 10b. County	10c. City, Town	or Location		10d. Inside City Limits
e Ma 8e-f		8 Waryland NI	4 Ba	Itimore		1 Ves 2 No
with th	à	10e. Street and Number	L 1.	10f. Zip Code	10g.	Citizen of What Country?
eath v	1	5/U2 remi	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin?	(Specify Voc or No	14. Race - American Indian,
fter d r Itan		Maryand N 10e. Street and Number 5702 Pem J 11. Marital Status 1 Never Married 2 Married	Armed Forces?	If Yes, specify Cuban, Mexican, Pu	erto Rican, etc.)	Black, White, etc.
yland 21215-0036 uid be filed within 72 hours after death with the Maryland Mental Hygiene. arked orther than "natural", or Itama 23a or 28e-f show aits event. The Medical Earnia et must be notified at	1	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: Black
5-0 72 hc 72 hc		15. Decedent's Ed (Specify only highest gra		Decedent's Usual Occupation (Give kind of work done during most of	working 16b	. Kind of Business/Industry
Mithin Mithin		Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)		M. I. L.
Hygie ther the	3	17. Father's Name (First, Middle, Last)	0	18. Mother's N	lame (First, Middle, Maid	VIIIAIU
lan Id be ental ked o	a	17. Father's Name (First, Middle, Last) Edward C	caia Sc	Res	ssie 7	Zrown
Maryland 21215-0036 d 2 should be tiled within 72 hours at th and Mental Hygiene. T? its marked other timen "natural", or traumatic event, the Medical Etum	-	19a. Informant's Name/Relationship (7	ype, Print Wire) 19b.	Mailing Address Street and Number or	Rural Route Number, Cit	ry or Town, State, Zip Code)
and 2 salth a n 27 is		Mrs. Helen (raig 5	702 Pembrok	e Ave. P	atto. Nd. 21207
Pages 1 Pent of He Int: If item		20a. Method of Disposition 1 Burial 2 Cremation 3	cometer	Disposition (Name of y, crematory or other place)	Date 20c	Location - City or Town, State
altimore, rmit. Pages 1 ar partment of Hea portant: If item vinjury or otha		`4 ☐Donation 5 ☐ Other (Specify	Garri	son Forest "	12004 Du	lings Mills, Nd.
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 15 marked of other than "natural; or Itama 23a or 28e-7 ehow any injury or other traumatic event. The Medical Eurning For Indiged.	once.	21. Signature of Funeral Service Liben	SOO DELLA	22. Name and Address of Facility	Funeral	Home and
		23a. Part 1. Enter the disease, or comp	lications that caused the death. Do n	ot enter the mode of dving, such as card	iac or respiratory arrest	Approximate
Dhysisi	9	Immediate Cause (Final	A A	ot enter the mode of dying, such as card		Interval Between Onset and Death
Physicia /Medic		disease or condition resulting in death)	a. Ventricu Due to (or as a consequence of		Q 710/1	
Examin	er	Commented the time and distance		lerotic cardio	vascular	disease
7 = g		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of			
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18760, cate be executed physician and the burial-transit				,,,		
687 ificate g phy:			d			
I Hecords, P.O. Box 6 The law requires that the death certificate the has been signed by the attending I age 2 should be deteched for use as age 2 should be deteched for use as	hy Dhyeirian/Ma	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 DEctopic pregnancy		23d. Date of delivery
O. E. e deal he att	12	in the past 12 months?	4☐Pregnant at time of death 9☐ Unknown	5 Other (specify)		Month Day Year
P.O hat the d by th	9	9 ☐ Unknown Part II. Other significant conditions co		the underking seven gues in Dart I	22a Did tabasa	o use contribute to the cause of death?
dS, F irres that signed t be ded	1 2	2	stributing to death but not resulting in	the underlying cause given in Part I,	1 ☐ Yes	/
Cord: w require been sig	j				24a. Was an	
The lay tate has page 2.					autopsy performed	
	Ba			26 Place of F	1 ☐ Yes 2 ☑ eath (Check only one)	No 1 Yes 2 No
of Vita Physicien: this certific al director,	- C	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 NOut	Other	Home 5 Residence	6 ☐Other (Specify)
DIVISION OF I or Attending Phy after death. Director: After this in by the funeral d			28a. Date of Injury 28b. T (Month, Day Year) In		28d. Describe how in	
SIO tendi leath. Ior: A	140	2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2 No		
or At or At after of Direct in by	Certification	4 Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
DIVISION Of VITA To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director. After this certifical completely filled in by the funeral director.	2		/sician: To the best of my knowledge	death occurred at the time, date and pla	ce, and due to the cause	(s) and manner as stated
ne Ho 7 24 h ne Fui	odina i	(Check only 2 Medical Exam	iner: On the basis of examination and and manner stated.	Vor investigation, in my opinion, death oc	curred at the time, date a	and place, and due to the cause(s)
To the To the Comp	Z	29b. Signature and title of certifier	m	29c. License number	29d. (Date signed (Month, Day, Year)
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111		30. Name d address of person who d		Type, Print)	Ilstown,	0.177
	Ct.	31. Date filed (Month, Day, Year)	32. Registrar's Signature	ad Kanda	112 DOWN!	1ND 21123
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State of Maryland / Department of Health and Mental Hygien 0 1 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** October 27 2004 3:58P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Joseph Ritchie Hospice Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Oct. 21,1922 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours 1 X M 2 □ F Yrs 217-12-5550 82 Director Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County itam 27 is marked other than "natural", or itams 23a or 28a-f shov other traumatic event, the Mudical Executor count be notified at 1 Yes 2 No Directo Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6110 Edmondson Avenue Apt C-3 21228 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. int: If itam 27 is marked othar than "natural", or ita 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2K No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retail 12 Salesman 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Patrick Henry Caughy, Sr. Anna Regina Starkey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5785 Victor Drive Eldersburg, Maryland 21784 John Caughy 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State injury or traint: 4 ☐ Donation 5 ☐ Other (Specify) 11/02/04 National Crematory Falls Church, Virginia 22, Name and Address of Facility Witzke Funeral Home of Catonsville, Inc. permit.
Departr
Importa
any inj 21. Signature of Funeral Service Licensee M00869 1630 Edmondson Ave. Catonsville, Maryland 21228 Approximate nterval Between Priset and Death 23a. Part1. Enter the disease, or complications that controls, or heart allure. List only one cause on a ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician nat /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medicai use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year ò in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II, Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2□ No 2 XV0 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Special 109 1 Yes 2 V 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Matural 2 Accident 5 Pending investigation 1 Tyes 2 No 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and tle of certifier 29c. License number M 30. Name and address of person who completed cause of deap (Item 23a) (Type, Print) M 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 1 - 2004 Registrar

State of Maryland / Department of Health and Mental Hygien 2004 34492 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month LARRY Year COLLINS 1405 PM 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HOWARD COUNTY GENERAL HOSPITAL HOWARD OLUMBIA If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1**X**M 2□ F 577-76-2753 Director 48 June 24,1956 Maryland Usual Residence of Decedent the Maryland Show 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Itams 23a or 28a-f shor traumatic evant, the Medical Examiner must be notified at Directo 1X Yes 2 No Maryland | Prince George's District Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or itams 23a or 2 any injury or other traumatic event, the Medical Evantical must be no once. 2031 Brooks Drive 20747 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 Widowed 4 Divorced **Black** Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th +02 Cook/Waiter Private Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Larry E. Collins, Sr. Martha Cramer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2002 Tiber Drive Martha J. Collins/mother Forestville, Md. 20747 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 10/25/04 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial Cemetery Suitland, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Frazier's Funeral Home, Inc. Mary E. Hedzman MO 389 Rhode Island Ave., N.W. Wash., DC 20001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute **Physician** intracerebral massive trough /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): sician and burial-transit To the Hospital or Attanding Physician: The law requires that the death cartificate be executed Due to (or as a consequence of): attending physician for use as the buria Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) of Vital Records, P.O. 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes → No 24a. Was an autopsy performed? 28 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Yes 2 ☐ No 1 Inpatient 28 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1. Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NGUYEN grace Colum 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV 0 1 2004

Registrar

State

2004

26,

OCTOBER

BESSIE CYMER

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2001 34494 For State Registrar AMEND ITEM #1 PER PHY C837 1 Province to part Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **JEANNETTE** CELAIRE Month **Physician** 10 A M October 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Northwest Hospital Center Randallstown Baltimore If Under 1 Year If Under 24 Hrs Months Days Hours Min. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Comm OF Dominico 1 ☐ M 2 1 F 580-25-0246 Director Usual Residence of Decede 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ♠No Director Baltimore isterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21136 or Items 23a Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by Specify: 3 Widowed 4 □ Divorced BIACK 'natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If Item 27 Ie marked other than "any rigury or other traumatic event, the Magnes. Elementary/Secondary (0-12) College (1-4or,5+ Housekeeper Home rivate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Maria Williams Douglas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
52-7F Frydendale, St. Thomas, VI 00802 Fridentale, S Loughter 52-7F Fruden
20b. Place of Disposition (Name of commeter), crematory of where place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State ` 4 □Donation 5 □ Other (Specify) 10-30-04 22. Name and Address of Facility Voughin C Greeke Funcial Sinks. 8728 Liberty Rd. Randallstown, MD 21133 21. Signatuçe of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ultiple **Physician** organ system tailure /Medical Examiner inflammatory response syndrome Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence burial-transit The law requires that the death certificate be executed Metastatic Imonth cancrealic physician 68760 Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ٥ in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) the Ö detached 9 Unknown 9 Unknown ģ ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably diabetes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No certificate of Vital Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 No 1 Inpatient Other: 얼 1 🗌 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 27. Manner of Death 1 Natural Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; To the Hospital or Attending Injury 5 Pending 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 24, 2004 028462 boolon N 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Northwest Center Randallstown, Maryland 21133 pita NOV 1 - 2004 32 Registrar's Signature State

Registrar

		•	1 - For State Registrar	State of Marylar	nd / Depa		of H	ealth a		ental Hy		•	34495	
		7	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year											
	Physicia /Medic		Mildred Peacock C	rowder					C	ctobe		2004	7:00P M	
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			Montgomery Hospic 5. Social Security Number 6. Sex	e Casey Hous 7. Age (In yrs.		Rockv		e If Under 2	24 Hrs. I a	Date of Birt		ntgomer	-	
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36	yland now		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits	
	e-fs	ctor	Maryland Montgomery	Bet	thesda								1 ☐ Yes 2X No	
	or 28	Director	10e. Street and Number			10f. Zip 0						n of What Cou	100	
	s 23e	rai	6312 Wicasset Road	. Was Decedent Ever in U	16 13	208			in2 /Cnooi	fu Vac or No		ed Stat		
	72 hours after death with the Maryland natural', or Items 23e or 28e-f show areal Examiner must be natified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	Amed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		If Yes, specif			, Puerto Ri	ify Yes or No- can, etc.)		Black, White		
Ş	2 hour		15. Decedent's Educa	tion	16a. Dece	dent's Usual	Oceupa	tion			16b. Kind	of Business/Ir		
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Mar	d 2 sho h and 7 Is m treum		19a. Informant's Name/Relationship (Type Janice Crowder Pul									Town, State, Zi	•	
e,	s 1 and 2 should f Health and Men item 27 Is marke other treumatic		20a. Method of Disposition	20b. i	Place of Dispo	sition (Name	e of		ct. 3			tion - City or T		
nor	0 0		1 ☐ Burial 2 🛣 Cremation 3 ☐ Rei 4 ☐ Donation 5 ☐ Other (Specify)	noval from State Mon	cemetery, crei ntgomen emator:	matory or oth	her place	9) 0	2004		Doth	ada M	aryland	
Baltimore,	permit. Pag Department Importent: I eny Injury o		21. Signature of Funeral Service Licensee		0803 B	Name and ethesd	Address	s of Facility hevy Mary1			Pump! 755	hrey Fu 7 Wisco	neral Home/ ensin Avenue	
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. Box	The law requires that the death certificate is the has been signed by the attending physicage 2 should be detached for use as the the the the the the the the the the	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	b. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of of 9 ☐ Unknown	al déath 3[□Ectopic pre □ Other <i>(spe</i>					23	d. Date of deliv Month	ery Day Year	
P.0	that the de led by the a detached t		Part II. Other significant conditions contri	ibuting to death but not res	sulting in the u	nderlying ca	use give	n in Part I.		23e. Did to	bacco use	contribute to t	the cause of death?	
Records,	uires tha signed Id be del	d by	Dementia							1 🗆 Y	es 2🖔	No 3 Pro	bably 4 Unknown	
cor	w require been si should I	Completed								24a. Was	an	24b. Were auto	opsy findings available	
Re	The law cete has page 2 s	dwc								autop perfor 1 Yes	med?	death?	ompletion of cause of 2 \sumble No	
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Division	Attending in death. ector: After by the fune	catic	2 Accident investigation 3 Suicide 6 Could not be			М		′es 2□N						
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	To the Hospitel or Attendi within 24 hours after death To the Funerel Director: A completely filled in by the fi	edical C		r: On the best of my kni r: On the basis of examina and manner stated.										
	withir To th comp	Me	29b. Signature and title of certified		_	29c.	License	number			29d. Date :	signed (Month,	Day, Year)	
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	12		30. Name and address of person who com Charles Harrison				Mil1	L Road	d, Ro	ckvill	e, Ma	ryland	20855	
	" Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Sign					_,					
h	Registi	ar	NOV 1 - 2004	Beneva	19	ppa	Ks							

State of Maryland / Department of Health and Mental Hygiene 004 34496 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Month Day Year **Physician** Ellen Cronise Covey October 26. 11:45 P M 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rockville Nursing Home Rockville Montgomery 8. Date of Birth (Month, Day, Year) December 18, 1918 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Davs Hours Months 1 □ M 2 🛛 F 218-05-3069 85 Yrs Maryland Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 27 is marked other than "neturel; or items 23a or 28e-f show treumatic event, the Medical Examinar must be molified at 1 X Yes 2 □ No Director Maryland Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 20850 831 Azalea Drive United States Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after on and Mental Hygiene.

Is marked other than "neture!, or liter 1 □Yes 2∑No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Teller Banking 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be George W. Cronise Mary C. Graff ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) s 1 and 2 st of Health ar fitem 27 is 831 Azalea Drive, Rockville, Maryland 20850 Joseph M. Covey /Son 20b. Place of Disposition (Name of cemetery, crematory or other place) November 5, 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Importent: If ite
any injury or otl 1 X Burial 2 Cremation 3 Removal from State 2004 Neelsville Cemetery Germantown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22, Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc. 4 Burs is M01305 23a. Part. Chter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Approximate Interval Between Onset and Death Immediate Cause (Final Cancer of Breast with Metastasis to Liver **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Cancer of Colon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certiticate be executed the attending physician and hed for use as the burial-transit Hepatic Encephalopathy Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🖾 No 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ After this certificate has been signe funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 X No 1 ☐ Yes To the Hospital or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No 2 ER/Outpatient 3 DOA 2 1 Yes 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Natural 5 Pending investigation after death. 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and tiffe of certifier 29c. License number 10sept October 27, 2004 U. D47330 amound 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 50 West Edmonston Drive, Rockville, Maryland 20852 Thomas V. Joseph, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 1 - 2004 Jacks, Registrar

			For State Registrar	State of N	laryland	•	artmen rtificat					iene g. No.2 ()	04	34497	
	Physici	an	Decedent's Name (First, Middle		mberla:	<i>-</i>				1	Date of Deat Month	Day	Year	3. Time of Death	
3	/Media	cal	Lois Je			T 11	4b City.	Town, or	Location		ctober		27, 2004 6:50 A M 4c. County of Death		
	Examir	ner	Mariner Health Silver Spring Silver Spring									ontgo	mery		
	Funeral Director		5. Social Security Number 505-20-5393	6. Sex 1 ☐ M XXF	Age (In yrs. last	t birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min. Dec	Date of Birth Month, Day, C • 24,	^{Year)} 1922	9. Birthp Coun Nebr	lace (State or Foreign try) aska	
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	Town or Lo	ocation						1	0d. Inside City Limits	
	s 1 and 2 should be filed within 72 hours after death with the Maryland f Heatin and Mental Hygiene. I them 27 is marked other than "naturat, or items 23a or 28a-f show other traumatic event, the Medical Examinations notified all	Director		tgomery			Silver Spring							1 ☐ Yes 2 🖾 No	
36			10e. Street and Number 1135 Universi	ity Blvd. W	#1109		10f. Zip		20902		10	Og. Citizen of V Unit	what Coun ed St	•	
		by Funeral	11. Marital Status 1 Never Married 2 Marr 3 TWidowed 4 Divorced	If Yes, Give	s? {No		Was Deced If Yes, spec		spanic Ori n, Mexicar Specify:	igin? (Specify n, Puerto Ricar	Yes or No- n, etc.)		e - Americ ck, White, : W		
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Maryland 21215-0036		Be	17. Father's Name (First, Middle, John	Last) Parkinson					18. Mothe	er's Name <i>(Fir:</i> Ruth	st, Middle, N	aiden Suman Kin	-		
aryl	2 should the and Meni is marked aumatic a	2	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address	(Street a	ınd Numbe	er or Rural Ro	ute Number,	City or Town,	State, Zip		
	1 and 2 Health a tam 27 is		Arthur L. Lap	pen/ Guardia								Bethe			
nore	permit. Pages 1 Department of He Important: If itan any injury or oth		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 4 ☐ Donatien 5 ☐ Other (S		chesa		sition (Nan natory or o		10	oct. 30	2	oc. Location - Belt:	-	e, MD	
Baltimore,			21. Sign lura of F neral S rvice	7 2 9	an	/ 22 R	Name an	d Addres	s of Facilit	d Crema	ation	Servic	es		
	40 F # 0		933 Gist Ave., Silver Spring, MD 20910 23a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate												
	nysician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. Hemorralic Stroke 6 weeks												
	/Medical Examiner			Due to (or a	is a consequen	ice of):									
	le death certificate be executed the attending physician and hed for use as the burial-transit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discuss of Mills)												
oʻ		Examiner	that initiated events c												
8760,		dlcal		d											
.O. Box 68		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 X Yeo 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)								23d. Date of delivery Month Day			•	
s, P	requires that the de leen signed by the a hould be detached to	by Ph	Tall in Other significant conditions continuing to death out not resulting in the underlying dates given at 1 art.								23e. Did tob	tobacco use contribute to the cause of death? Yes 2 № No 3 Probably 4 □Unknown			
Record	w require been sign	eted									24a. Was an		1	sy findings available	
l Rec	has has	Completed									autopsy perform	ed?	rior to con leath?	ipletion of cause of 2□ No	
Vital	Physician: The this certificate ral director, page	Be	25. Was case referred to medical examiner?	Hospital:				Othe		of Death (Che					
of		n: To	1 ☐ Yes 2 ☐XNo 27. Manner of Death	28a. Date of In		b. Time of		Bc. Injury Work	4E3 Nursing Home 5 Residence 6 Other (Specify)						
sion	Attanding I r death. ector: After by the funer	catlo	1 X atural 5 Pending investigation 2 Accident 3 Suicide 4 Homicide 4 Homic												
Division	F the F	Certification:										Houte Number,			
	To the Hospital of within 24 hours af To the Funeral D completely filled in	ledical (ng Physicien: To the bes Examiner: On the basis apal manner:	of examination										
	To tha within 2 To tha complet	Me	29b. Signature and title of certifie			11 1	290	. License	number		29	d. Date signed	(Month, E	Day, Year)	
	1		* ATELL	Kowekra		11.1		DC	9834			Octob	er 28	3, 2004	
	Q		30. Name and address of person Barry Rosenba	who completed cause of aum, M.D.; 3	death (Item 23 3720 Fa:	^{Ba)} (Type, rragu	Print) L t Ave	e., K	Censi	ngton,	MD	20895			
	Sta		31. Date filed (Month, Day, Year)	32. Regis	trar's Signature	9									
	Regist	el s	NOV 1 - 20	104 Barner	med f	J	Som	Ka/							

			For State Registrar	State of Ma	ryland /	Departm <i>Certific</i>	ent of F ate of	lealth and <i>Death</i>	d Mental H	lygier Reg. 1		004	34498			
	Dhysici		1. Decedent's Name (First, Middle, La	st)		_			2. Date of Month		ay	Year	3. Time of Death			
	Physici /Medic									5/20	04	ı oai	3:50 A M			
	Examin	er	4a. Facility Name (If not institution, giv			4b.		or Location of De	eath		tc. County					
	-			Oak Lodge Senior Care Home Pasadena 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. D.							nne	Arur	nde1 lace (State or Foreign			
	Funeral Director			MM 2□F	90	Yrs. Mor			in. (Month.	Day, Yea 24/1	914	Cour	nace (State of Poreign htry) MD			
	0		Usual Residence of Decedent					1	1037.	- 1/ -			11D			
	srylan show	_	10a. State 10b. County		10c. City, Tow	n or Location						1	0d. Inside City Limits			
	permit. Pages I and 2 should be liled within 72 nouts after death with the maryland Department of Health and Mential Hygiene. Department of Health and Mential Hygiene. Innportent: If them 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at Once.	Director	MD Anne A	rundel	Pasa	dena				-			1 □Yes 2 No			
		Dire	10e. Street and Number			101	. Zip Code	_				What Cour	itry?			
	98 23 Out	Funeral	7902 Elizabeth 11. Marital Status	ROad 12. Was Decedent Ev	er in IIS	13 Was D	21122		(Specify Vas or		. S . A	e - Americ	an Indian			
•	riten	Fun	1 ☐ Never Married 2 Married	Armed Forces? 1 ★ Yes 2 □ No If Yes, Give		If Yes,		an, Mexican, Pu	(Specify Yes or erto Rican, etc.)	140-		ck, White,				
	ai', o	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1945	1 🗆 Ye	s 2K No	Specify:			Specify	w Whi	te			
ָ ה	natur natur	Completed	15. Decedent's Ed (Specify only highest gra	ducation de completed)	16a	. Decedent's	Usual Occup	ation during most of v	workina	16b.	Kind of B	usiness/Ind	dustry			
V :	han *	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)				during most of v d)			dera					
V	lled v lygie her t		17. Father's Name (First, Middle, Last)			Super	inter		lame (First, Mide			ment				
	ed of	Be c	Woodson Dishma								en Surran	10)				
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<u> </u>	ulth ar lith ar 27 is r trau		Bruce Dishman/	**					Pasade							
ָם פֿר	othe		20a. Method of Disposition		20b. Place o	f Disposition ry, crematory	Name of		Date			City or To				
	Page nat: if iry or		1 Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify						/29/04	G1	en B	Burni	e, MD			
	ermit. Sepertri mporte iny inju		21. Signature of Funeral Service Licer			22. Nam	e and Addres	ss of Facility	J.Gor	ice	Fune	ral	Home, PA			
	20 = 6 G		23a. Part1. Enter the disease, or com-	plications that gauged th	a doath Do						dena	, MI	21122			
	*		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	death. Do	not enter the	mode or dyln	ig, such as card	iac or respirator	arrest,			Approximate Interval Between Qnset and Death			
	hysician and business and street		disease or condition resulting in death)	a. 5 (10	NE	0 11							5 y Reis			
				Due to (or as a	consequence	10/1/t	101					/	Oword			
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O	ding p se as		IF FEMALE:	23c. If yes, outcome of	pregnancy											
ם פ	etten for u	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at tir	Fetal death	3 □Ectop 5 □ Other	c pregnancy				Mor		of deliv <i>er</i> y h Day Year			
5	wiequires trial the death certil been signed by the ettending should be detached for use a	Physician/M	1 Yes 2 No 9 Unknown 9 Unknown													
L ;	ned b e deta	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death?						
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ָ כ	as be 2 sho	pie							24a. W	as an topsy	346. V	Vere autop	sy lindings available			
	ate h page	Completed								rformed?	d	eath?	20 No			
A I La	sertific ector,	Be	25. Was case relerred to medical examiner?	Hospital:			04		eath (Check onl	y one)			Andello			
5	this cal dir	2	1 Yes 2 No	Hospital: 1 ☐ Inpatient 28a. Date of Injury		tpatient 3	DOA Othe	4 Nursing	Home 5 ☐ Re			or (Specify,	Facility			
5 8	After fune	tion	1 Natural 5 □ Pending	(Month, Day Y	rear)	njury M	28c. Injury Work	Yes 2 □No	200. 0000110	e now inju	Jry occurre	90	1			
101	death ctor: y the	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury	- At home, la				28f. Location	8f. Location (Street and Number or Rural Route Number,						
5 3	s afte	Certification:	4 Homicide	building, etc. (Specify)				City or T	own, Stat	řθ)					
3	To the national age of the factor of the factor of the factor of the factor of the factor, based of the factor, based of the factor, based of the factor, based of the factor of the fac	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										ited. the cause(s)			
4	within 7	Mec	29b. Signature and title of certifier	and manner state	1_		29c. License	number :		29d. Da	ate signed	(Month, D	ay, Year)			
			· GULTY	pla	5 0	7	0	2009	14		10/	26/	04			
	11		30. Name and address of person who	completed cause of deal	h (tem 23a)	Type, Print)	adi.	D.	K 111	111	Ma.	BIL	all und			
	(() Sta	te	31. Date filed (Month, Day, Year)	32. Regular's	Signature ,	-	4	7 /	UI - IJ	1	U UPL		May 2106			
	Registra		NOV 0 1	2004	אל הונו	App	42)									

State of Maryland / Department of Health and Mental Hygiene 2004 34499 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** DECKER 5:18 AM EONARD OCTOBER 29 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARBOR BALTIMORE HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 128M 2□ F 212-28-0515 Yrs. Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits s 23a or 28e-f show ust be notified at ARUNDE 1 ☐ Yes 2 No Director ANJUE LFN MURDIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ()SA THE WATER 21061 Items 23a Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. traumatic event, the Mudical Examiner of Armed Forces?

1 Yes 2 No
If Yes, Give 2 should be filed within 72 hours after or and Mental Hygiene. Is marked other than "netural", or Iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 🗓 0 Specify: If Yes, Give Year or Dates: þ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ANTO MOTIVE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be TRIF IORRIS THA. IDO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Department of Health a Importent: If item 27 Is any injury or other tran <u>once.</u> 1300 BLOVEWATER CT. 201 GENBARNIE MOZICH 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State OVERVED MI GARDENS OF 4 Donation 5 Other (Specify) 2004 CHAPEL OF 21. Signature / Funeral Service Licensee 22. Name and Address of Facility M01220 8800 HARFORD BACTIMORE, MD 21234 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician a. REFRACTORY METABOLIC HOURS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner SYSTEMIC DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit OAYS AIMOMUSH Due to (or as a consequence of) 68760. LOWER Physiclan/Medical ISCHEMIA DAYS IMB. the as Box IF FEMALE esn esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month 4 Pregnant at time of death 5 Other (specify) P.O. ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by CM3 RENAL STACE 1 Yes 2 No 3 Probably 4 Winknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No CONGESTIVE 24a Was an page 2 s has 1 ☐ Yes Division of Vital 2 110 Hospital or Attending Physician: director. Be 25. Was case referred to medical 26. Place of Death Check on one examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 LNO 1 Thipatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 DMatural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: 6 Could not be determined 3 Suicide i 24 hours after de e Funerel Directo letely filled in by ti 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) PGY-3 -16775 OCTOBER, 29, 2004 MIRIST who completed cause of death (Item 23a) (Type, Print) (im HATIC 23100AH BALTIMORE, MO-21225 31. Date filed (Month Ray, Year) 32. Redistrar's Signature State 12 more Darko A Registrar

State of Maryland / Department of Health and Mental Hygien 2004 34500 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 5:30 PM 2004 Helen October 29 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Bayview Medical Center Balthmore Hopkins N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct 4, 1919 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1 □ M 2 🔀 F 217-07-6198 85 Director Md. Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits rthan "netural", or Items 23a or 28a-f show the Medical Examinar must be notified at Dundalk 1 ☐ Yes 2 XNo Director Baltimore Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1589 Lynch Rd. 21222 USA Funerai Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after rent of Health and Mental Hygiene.
ent: If Item 27 Is marked other than "netural", or Itel ury or other traumatic event, the Madical Examina 1 □ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Housewife 6 yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Helen Hobbs John Chilcote 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1589 Lynch Rd. Dundalk Md. 21222 George Earle son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Importent: If It any injury or o Nov. 2, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cem. Baltimore 1 4 □ Donation 5 □ Other (Specify) 2004 21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death failure Immediate Cause (Final disease or condition resulting in death) Cardiac **Physician** /Medical Due to (or as a consequence of): **Examiner** Pancrealitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Sepsis Month Due to (or as a consequence of): physicien ar Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☑No Month Day 5 Other (specify) 4☐Pregnant at time of death P.O. 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ renal disease, Hypothyroidism 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No autopsy 2 No certificate 1 ☐ Yes or Attending Physiclan: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🐪o 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 3 🗀 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours el To the Funerel D completely filled i the Hospital 29a. Certifier 1 🗷 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 29, 2004 October 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Md 4940 Eustern Avenue John Eckman 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL